

West Sussex Substance Misuse Health Needs Assessment

2021

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1. Executive summary

1.1 Synopsis

The misuse (or excessive use) of drugs and alcohol have been linked to a range of negative impacts for individuals, families and communities, including early death, long term health conditions, reduced quality of life and economic opportunities, and increased social issues, including homelessness, violence and exploitation, requiring interventions from state and community-level service provision. National guidance and government policies outline potential actions for improving outcomes related to substance misuse. A necessary component for such action is a local-level examination of the facts, in the form of this health needs assessment.

This report is a part of the Joint Strategic Needs Assessment for West Sussex so contains information for system-wide plans, including CCG commissioners, partnership leads, and all those concerned with drug and alcohol use, community safeguarding, population health, policing and adult and children's social care. Its purpose is to provide an up to date summary of substance misuse issues in West Sussex, including figures on vulnerable populations and health-outcomes, particularly pertaining to wider social determinants and other drivers of poor health seen in the literature, and has been requested by local substance misuse commissioners to support decisions taken in the planning, commissioning, and provision of services.

The report covers a number of sections and it may not be necessary for the reader to review all these. For ease of reading the sections and main sub-heading are included below. Each section includes at its end a summary box of key issues and these key issues are included in this executive summary; further context and detail are included in the main document.

Section 2 – Background and information

The first section introduces the national context, relevant government/select committee priorities and NHS plans for substance misuse issues, as well as how this work fits in with local priorities. It also sets out the purpose and structure of the needs assessment for the reader.

- 2.1 National policy
- 2.2 Local priorities
- 2.3 Aims and objectives

Section 3 - Local population

This first data section describes the local population characteristics relevant to the rest of the document, where county and district-level data are often used. Relating later sections back to this population summary should give a clearer picture of how issues can affect some communities or cohorts more than others and aid local targeted approaches.

- 3.1 Population and geography
- 3.2 Population demographics
- 3.3 Multiple Deprivation and local inequalities

Section 4 - Prevalence in the community and higher risk groups

This section covers the local scale of alcohol and substance misuse in West Sussex and using a range of data sources these includes both estimates and observed incidence.

- 4.1 Alcohol misuse in the general population
- 4.2 Drug misuse in the general population
- 4.3 Families and substance misuse
- 4.4 Young people and substance misuse
- 4.5 Substance misuse amongst sex workers
- 4.6 Exploitation through county lines and modern slavery
- 4.7 Homelessness and housing issues
- 4.8 Learning disabilities

Section 5 – Community level impacts of substance misuse

This section covers the main health-related outcomes related to substance misuse and how those from vulnerable groups identified in previous sections may be more affected in these outcomes.

- 5.1 Mental health conditions
- 5.2 Smoking and Chronic Obstructive Pulmonary Disease
- 5.3 Sexual health
- 5.4 Blood-borne viruses (BBV)
- 5.5 Alcohol related hospital admissions
- 5.6 Deaths related to drug and alcohol use
- 5.7 Alcohol and drug-related crime

Section 6 - Alcohol and drug treatment service users and unmet needs

This section covers the data relating to residents using drug and alcohol services in the community. Understanding how these locally commissioned treatment services are supporting local residents can help commissioners and providers to adapt and refine service provision, as well as expanding partnership opportunities. Much of this data is taken from the National Drug Treatment Monitoring System (NDTMS).

- 6.1 Numbers of service users in treatment services
- 6.2 Characteristics of service users in alcohol treatment services
- 6.3 Characteristics of individuals in drug treatment services
- 6.4 Harm reduction interventions
- 6.5 Meeting estimated need for alcohol and drug users
- 6.6 Referral routes into treatment and waiting times
- 6.7 Treatment settings

- 6.8 Length of treatment and retention
- 6.9 Successful and unsuccessful treatments

Section 7 - Mental health and pathways for co-existing conditions

- 7.1 National recommendations for co-occurring conditions
- 7.2 Coexisting mental health and substance misuse conditions in West Sussex
- 7.3 Investment for the future

Section 8 - COVID-19 response and new ways of working

Due to the 2020 global outbreak of the disease Covid-19, in Spring 2020, providers of substance misuse prevention and treatment services have been developing new ways of working, particularly in the context of government mandated 'lockdowns' and a reduction of person-to-person contact in some, - but not all, - community settings. This section documents the changes to service provision during this time and also attempts to learn from new ways of working.

- 8.1. Service planning and the public health context
- 8.2 Effects of the lockdown on service outcomes
- 8.3 Lessons learned for the future

Section 9 – Reflections and partnership feedback

This summary to this needs assessment (Section 1) was drafted in late-2020 and shared with West Sussex Community Safety Managers, public health leads, several members of the Safer West Sussex Partnership executive board and key community partners involved in supporting those with substance misuse issues. These stakeholders were asked to provide feedback on the content, approach, and findings of the needs assessment, as well as recommending key areas of future activity.

- 9.1 Feedback on the needs assessment
- 9.2 Core areas of focus for the future
- 9.3 Known gaps in knowledge or ability to improve services
- 9.4 Suggested priority actions

Section 10 – Recommendations and gaps in knowledge

This section contains the final recommendations from the needs assessment, as well as acknowledgements of the need for future work to fill gaps in knowledge. (See Section 1.3 below for details).

1.2 Key points

Section 2 - Background and introduction

In 2019, the UK Health and Social Care Committee, recommended a radical change in UK drugs policy moving from a criminal justice to a health approach, where responsibility for drugs policy rests with the Department of Health and Social Care and not the Home Office.¹

The Committee recommended a comprehensive approach to drugs, including improving treatment services, introducing harm reduction interventions, and better education, prevention and social support. The Committee noted that while evidence-based guidelines for treating people with drug dependency do exist, there is an unacceptable gap between best practice and what services are actually able to deliver to people. The committee also noted wide variation in the level and quality of services provided. They called on the government to direct significant investment into substance misuse treatment services.

In 2017, the UK government launched the national drug strategy, in which they estimated the social and economic cost of drug supply in England and Wales to be £10.7 billion per year.² The strategy was framed around several themes, including: Reducing demand; Restricting supply; Building recovery; and Global action. There is no current national alcohol strategy, but in the previous strategy (which ran to 2015) the government anticipated that work to tackle harmful alcohol use be led by local authority Public Health departments, Health and Wellbeing Boards and Police and Crime Commissioners. They also cited the need for multi-agency working and the clear link between harmful alcohol use and poor mental health.

At a local level, alcohol and drug use is mentioned throughout the West Sussex Joint Health and Wellbeing Strategy in the context of improving health behaviours and reducing inequalities; at start of life, for children living in households of harmful alcohol and drug use; and for living well, in terms of health behaviours which may have contributed to the stall in increase in life expectancy.³

The Safer West Sussex Partnership has a series of priorities for the year 2020/21 in the refreshed Safer West Sussex Partnership Community Safety Agreement 2016-2020, including this needs assessment; a multi-agency Reducing Drug Related Death action plan, building on the findings of the Drug Related Death Audit; expanding the provision of Naloxone; supporting those with homelessness/housing issues to improve health outcomes; supporting those with co-existing

¹ UK Parliament, [Health and Social Care Committee](#) (2019)

² UK Home Office, [Drug Strategy 2017](#) (2017)

³ West Sussex Health and Wellbeing Board, [Start Well, Live Well, Age Well: West Sussex Joint Health and Wellbeing Strategy, 2019-2024](#) (2019)

mental health and substance misuse issues; and to carry out analysis of the size and scale of the illegal drugs market in a local town in order to better understand the demand and supply.

This needs assessment, via a range of methods and data sources, aims to provide service commissioning leads, executive boards, and providers with the detailed analysis they require to continue to support those with substance misuse issues, both directly and indirectly.

Section 3 - Local population

West Sussex has roughly 860,000 residents and overall, the county has an older age profile than the national average. Crawley is an exception, with a younger age profile than England.

West Sussex has a lower Black, Asian and Minority Ethnic (BAME) population than the South East, with 88% of residents identifying as White British in 2011. Crawley is an exception, where 72% identify as White British. BAME residents are known to face different barriers to services and health inequalities have been documented.⁴

There are strong links between poverty, deprivation, inequalities, and substance misuse. Poverty and disadvantage can act to increase the risk of substance misuse, and substance misuse can lead to increased disadvantage. These inequalities can also lead to barriers in accessing services and poorer health outcomes. Each district and borough has some areas of higher deprivation, though these are more consistently focused in the urban areas of the coastal strip and in west Crawley.

Due to the range of social determinants, partnerships from a range of organisations are required to address drivers of substance misuse issues, from each unique angle.

Section 4 - Prevalence in the community and higher risk groups

Overall numbers and assumptions: From 2018 estimates, there are between 5,500-9,500 residents in West Sussex in need of treatment for alcohol dependence (point estimate of roughly 7,000).⁵ Other research estimates that roughly a quarter of West Sussex adults (165,000 residents) drink above the recommended low-risk levels.⁶ From 2018 estimates, there are between 1,200-3,200 residents using opiates and/or crack cocaine in West Sussex.⁷ As it can be difficult for authorities and providers to identify or reach out to residents with substance misuse

⁴ PHSRU, [Black, Asian and Minority Ethnic Communities in West Sussex](#) (2016)

⁵ Estimates are calculated by the National Drug Treatment Monitoring System (NDTMS), based on modelled estimates of use in the population at the local authority level.

⁶ Estimates are calculated by the Public Health England: Risk Factors Intelligence (RFI) team.

⁷ Estimates are calculated by NDTMS, based on modelled estimates of use in the population at the local authority level.

problems in the community, it is necessary to focus on areas with proxy-indicators for drug use (i.e. economic inequalities) to increase the chances of engaging with these residents.

Environmental data: One way of monitoring local activity has been via working with local District Council environment and street cleaning departments. From their information roughly 3,500 pieces of drugs litter were identified in West Sussex from 2016-2020, and whilst data are incomplete, roughly half of these are needles, barrels or syringes. Use of Nitrous Oxide has been a recent priority in Worthing and Adur, and findings of used gas canisters there account for 89% of all recorded canisters county-wide.

Pregnancy: We also can target specific risk groups to tackle problems for example, heavy alcohol use during pregnancy can lead to foetal alcohol spectrum disorder, a term that encompasses a range of alcohol-related birth defects; affecting up to 3% of all children.

Children living with an adult with alcohol or drug dependency: PHE estimate that there are 2,700 children in West Sussex living with an adult with alcohol dependency, though only 375 children are known to live with an adult who entered alcohol treatment in 2019/20. Roughly half of alcohol service admissions are parents or live with children and 14% of these service users are also known to children's services. Over half of new drug service admissions are parents or live with children and 23% are also known to children's services.

Children's services: In West Sussex, children's services assessments have increased from roughly 7,400-10,500 from 2014-19. Of these, roughly 2,150 assessments (20%) made reference to adult substance misuse (either drugs or alcohol). Over 1,100 of these also made reference to co-occurring adult mental health problems (11% of all children's services assessments).

Young people: Risk factors for young people engaging with substance misuse include mental health issues; experience of domestic violence and sexual exploitation; not being in Education, Employment or Training; being exposed to parental substance misuse; being in care or a care leaver.

Sex workers: A range of recommendations exist to support those engaged in sex work; work which can lead individuals to having considerable, mental and physical health problems.⁸ Not having problematic drug use as a principal motivation for sex work is one of the most important factors for leaving sex work. Ceasing problematic drug use is seen as the 'key to freedom' from being trapped in multiple vulnerabilities.⁹

Modern slavery and county lines: In 2019/20 Sussex police recorded 250 incidences of trafficking controlled drugs and 150 incidences of modern slavery crime in West Sussex. Multiagency working

⁸ DrugScope and AVA, [The Challenge of Change: Improving services for women involved in prostitution and substance use](#) (2016)

⁹ UK Home Office, [Vulnerability and involvement in drug use and sex work](#) (2003)

is important in tackling county lines. Those involved with county lines, particularly children and vulnerable adults can be considered both as victims and offenders and a balance is needed between safeguarding victims, disrupting criminal operations and prosecuting offenders.

Homelessness and housing: Those with housing or homelessness problems are at a greater risk of the harms of substance misuse and this is especially so for rough sleepers (4 in 5 of which had taken drugs recreationally in the past year, locally in 2016). At the same time, substance misuse can be a factor leading to housing problems and homelessness.

Learning difficulties: Efforts should be made to understand the guidelines and advise for identifying and supporting those with learning difficulties who might be suffering from substance misuse issues, as current provision may not always be accessible or appropriate. Those with less visible difficulties are more likely to go unnoticed, which can reduce the success of community support.

Section 5 - Community level impacts of substance misuse

The occurrence of mental health conditions among people with substance misuse problems is very common and this two-way relationship is complex.

- Of new presentations to alcohol treatment in West Sussex in 2019/20, 54% were identified as having a mental health need. Of those, roughly 23% of males and 16% of females were not receiving any professional support for assessed mental health problems.

- Of the adults who entered drug treatment in 2019/20, 60% were assessed as having a mental health treatment need. Of these, roughly 32% of males and 21% of females were not receiving any professional support for assessed mental health problems.

Tobacco use is far higher amongst those with substance dependencies and many reasons exist for this increased use. A considerable number of those using services quit smoking during treatment, but many also take up smoking to offset the loss of the other substance.

Sexual health providers are working closer with substance misuse providers. This improved joint working, including opportunistic access to sexual health for drug and alcohol clients, and having substance misuse services on key stakeholder lists for the sexual health strategy group.

Preventable bacterial infections are increasing amongst people who inject drugs and the cause is likely to include the ageing populations within this group who can have poorer vein and skin health, changes in injection practices with recent increases in groin injections, increasing homelessness, and likely conditions of poorer general hygiene and more unsterile injecting. Use

of personal injecting kits is encouraged and despite low HIV levels, risks from HIV and Hepatitis B and C continue.¹⁰

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Locally, admission episodes for alcohol-related conditions have been increasing (from 500 to 585 per 100,000 residents in the last ten years) and there is a need to explore and address the inequalities in alcohol-related health outcomes and higher hospital admissions in the coastal towns of West Sussex, which are above national averages, and particularly so for females aged under 40 years.

Broadly speaking, alcohol-related deaths make up around 5% of all deaths nationally. Increasing alcohol-related mortality rates in West Sussex are now higher than regional averages, and in line with national averages. Drug use disorders are the third highest cause of death in the 15–49 age group in England.

Locally West Sussex has lower rates of drug death than the national average. A review into local drug-deaths identified a range of factors inhibiting successful recovery, including mental health issues; diagnosis, gatekeeping and systems issues creating barriers to accessing support; education around safe drug use (including medications); and complex individual lives making accessing or continuing in recovery more challenging.

Roughly three quarters of drug-related crime involves cannabis. Drug crime is more concentrated in Crawley, Worthing and Arun. West Sussex performs poorly compared to the South East region in engaging prison leavers in drug treatment within three weeks (roughly 20% compared to 34%, respectively).

Section 6 – Describing alcohol and drug treatment services and their users

Public Health England estimates that alcohol treatment reflects a return on investment of £3 for every £1 invested, which can increase to £26 over 10 years. Drug treatment provides a return on investment of £4 for every £1 invested, which can increase to £21 over 10 years.¹¹ Treatment can be enacted and expanded through a range of evidence-based mechanisms.

Due to wide estimates of prevalence, it is difficult to estimate how many residents need treatment, but are not receiving it; estimates range from hundreds to thousands.

Alcohol treatment service use in West Sussex has increased in recent years, from roughly 650 to 1,100 residents per year (roughly 60% males; 40% females). Approximately 40% of these were

¹⁰ PHE, [Shooting Up: Infections among people who inject drugs in the UK](#) (2019)

¹¹ PHE guidance, [Alcohol and drug prevention, treatment and recovery: why invest?](#)

in regular employment at start of treatment and 13% had housing problems. This highlights the considerable social and economic challenges people with substance misuses problem can face and the range of issues which services need to support people to overcome.

Opiate service use in West Sussex has remained relatively stable, around 1,150 residents each year, but numbers of non-opiate service users have doubled, from roughly 150 to 300 residents each year (roughly 70% males; 30% females). Regular employment may be an indicator for a higher likelihood of completing opiate treatment. Thirty one percent of people are employed at start of treatment. A recognised housing problem was recorded for one in three opiate service users.

In 2017, 17% of the national population used antidepressants and 13% used opiate pain medications. The Faculty of Pain Medicine estimate that 8-12% of long term prescribed opioid users would currently, or in the past, meet the criteria for an opioid use disorder.¹² In West Sussex, there were 85 residents in treatment for prescription-only medicines (POM) or over-the-counter medicines (OTC).

In line with national guidance, over 95% of opiate service users have been supplied with Naloxone by June 2020. Services have provided 500-900 residents a month with needles, syringes and other equipment used to prepare and take drugs.

Informal referral pathways for alcohol and drug services (i.e. self-referral, or by friends and family) have increased in the past decade from roughly half to nearly four in every five. It is assumed that this relative change is driven by both a decline in formal pathway referrals (i.e. criminal justice, or health services), and by expanded awareness in the community. The majority of service users were recorded as starting treatment within three weeks of their referral.

Nearly all of alcohol and drug treatment occurs in community settings, but from 2018-20 there were 103 residential placements for detoxification and rehabilitation treatments; 76% of service users completed their residential treatment.

Two thirds of successful alcohol treatments last under six months, but 8% last more than a year. Opiate treatments are most effective when completed within two years, but one in four service users in West Sussex have been in treatment for more than six years (in line with the national average). Decisions over how long an individual should ideally be in treatment often comes down to personal circumstances and safeguarding concerns.

Successful completions of treatment for alcohol services have fallen from highs of over 70% in 2014 to roughly 55% in 2019, with drop-out rates in the same period increasing from 15% to over 40%. In the same time, roughly 7% of those receiving opiate support died (from any cause)

¹² Faculty of Pain Medicine, [Terminology and prevalence](#) (2020)

whilst in treatment and drop-outs in West Sussex increased from around 20% to 45%. These are comparable with the national picture.

Public Health England benchmark the performance of treatment services by whether people complete treatment and do not represent to treatment within six months of completion. Of those receiving alcohol treatment in 2018/19, 35% completed their treatment and did not represent to the service within six months. Of those receiving opiate treatment and non-opiate treatment in 2018/19, 8% and 35% (respectively) were able to complete treatment and not return to services within six months, which was similar to national levels.

There is local provision of outreach support, but levels may be worth further exploration and review, in line with PHE recommended mechanisms for improving access and retention for services. For example, factors associated with increased service retention include being in education or employment, being in good physical health, and not drinking alcohol every day. Factors decreasing the likelihood of successful treatment include having housing problems, living in an area of higher deprivation, previously dropping out of treatment. Other outreach can include needle and syringe programmes, open sessions and sessions restricted to particular groups and issues, providing transport and childcare, and ensuring effective and supported pathways to treatment from prison.¹³

Changes in the service specifications in 2016/17 may explain the fluctuations in some performance and service indicators. This includes an expansion of services (particularly alcohol services) and may explain the increase the informal (self) referrals, which in turn may affect the successful outcomes or length in treatment. Closer examination may be required to the contexts and mechanisms behind outcomes seen.

Further exploration is warranted to find out why local and national drop-outs and successful completions (particularly for opiate treatment) shifted after 2012. This may be for example, due to changes in pathways, with an increase in self-referrals, or due to a change in wider approaches.

Section 7 - Mental health and pathways for co-existing conditions

National policy and guidance clearly outline the need to address co-existing mental health and substance misuse problems and these combined are more complex than the existence of two separate issues. They have a heightened risk of other health problems and early death (a higher prevalence of smoking also contributes to this increased morbidity). Individuals with coexisting conditions are shown to frequently be excluded from mental health services when intoxicated and from substance misuse services when experiencing mental health crises.

¹³ Source: PHE, [Health matters: preventing drug misuse deaths](#) (2017)

PHE have published five priority recommendations to support these individuals, including:

- agreeing a care pathway that delivers collaborative care;
- ensuring every individual is assigned a named care coordinator;
- undertaking joint commissioning, enabling people to access the care they need;
- commissioning a '24 hour, 7 days a week' response to those experiencing mental health crisis, even when intoxicated;
- and ensuring individuals are helped to access a range of recovery support.

In West Sussex, roughly half of all those accessing alcohol or drug treatment services were identified as also having a mental health need. Of those with mental health needs, roughly 19% of alcohol treatment service users and 28% of drug treatment services users were not accessing any support for known mental health problems.

Nearly half (45%) of all those identified in a West Sussex rough sleeping/homelessness audit in Summer 2020 were identified as having both mental health and substance misuse needs.

In a three-year period (2015-17), 66% of those who died from drug misuse or other drug poisonings in West Sussex were identified as having mental health needs (60% of those who died specifically from substance misuse). Depressive illnesses and anxiety-related illnesses were the most common issues for those who died. The audit found evidence of local barriers similar to those described in PHE's national review.

There is recently new local investment into drug and alcohol and mental health services to address issues of coexisting conditions, but potential gaps in our understanding of these issues remain. To maximise the impact of this investment it is necessary to continue to explore the health needs of this vulnerable group of people. This will require cooperation across partnerships to deliver improved outcomes.

Section 8 - COVID-19 response and new ways of working

The nation-wide lockdown of March to July 2020 and the subsequent ongoing policies of reduced interpersonal proximity have led to significant challenges in service provision and wider support mechanisms. Workforce Management and the Staffing/Health and Safety/Governance concerns included an agreed organisational response to ensure consistent Risk Assessments are in place.

The main programme activities, i.e. Medication Assisted Treatment, Alcohol Offer, Harm Reduction activities, have remained in place. Some major providers have agreed to pause face-to-face meetings to assess new referrals, but digital/telecoms channels remained open. This has been kept under regular review. Some work still exists as face-to-face, such as those concerning homelessness support and those interventions for people with higher clinical need.

Some services have kept service users engaged, when they might have otherwise completed their treatment and been discharged as a safeguarding measure.

Contacts and check-ups with service users have switched to telephone contacts where possible and preliminary feedback suggests this may be a positive step, as it allows for more flexibility and less missed appointments than when service users are required to go to a central location. Implications for this should be reviewed with professionals and service users to assess the full extent of positive and negative impacts of this change in working.

For the first half of 2020 there was an increase, in relative and absolute terms, in service users receiving Medically Assisted Treatments who were not also using illicit drugs. It has been proposed that this was due in part to the reduction of illicit drugs caused by the national lockdown and this should be monitored long-term to see if this change is sustained.

Section 9 – Reflections and Partnership feedback

The summary to this needs assessment (Section 1) was shared in late-2020 with the West Sussex Community Safety Managers, several members of the Safer West Sussex Partnership executive board and key community partners involved in supporting those with substance misuse issues.

Overall, the partnership feedback was positive, and it was felt that the approach and format of the assessment was both clear and valid. Limitations included the lack of engagement work, meaning that context was missing from the explanation of some of the observed issues and barriers to improvements; this will need to be explored at a later date to continually grow the local evidence base.

Areas to focus on in the future included co-existing mental health issues; supporting people holistically, to take account of individual complexities; an understanding of how the local community interacts with vulnerable groups; strengthening partnerships to support younger people; refocussing on prison leavers; and a need to better employ local data to enable workstreams and partnerships.

Known gaps in knowledge or ability to improve services included how best to support those with coexisting mental health conditions, as well as those in vulnerable groups, particularly homelessness, in light of the community impact of Covid-restrictions. Also highlighted was the need for psychologically informed environments and for a balance between clinical treatments and psycho-social support and asset-based approaches. How these might be incorporated and commissioned was unknown. The question of how to engage and develop the local partnerships to work together in new ways was also raised; as was the opportunity to review probation service data to help inform what could be done to improve outcomes for ex-offenders. Further detail was also requested on young people's involvement and use of drugs, alcohol and possible unregulated use of prescription medications, and how these might link to crime or exploitation.

Many priority actions were suggested by our partners. These included:

- Better joined up systems;
- Wellness in the community to reduce self-medicating with substances;
- Tighten relationships within related systems;
- Provide a rolling programme of drug and alcohol training to upskill the wider partnership workforce;
- Increasing engagement and ease of travel through referral pathways;
- Developing and improving early intervention;
- Opportunities to work alongside primary care nurses and GP based paramedics;
- Improve prevention and end-of-treatment strategies;
- A specific focus on the consumption and supply of cannabis;
- Maintaining service engagement and reducing unplanned exits;
- Developing practice around coexisting conditions;
- A regular review of the impact of Covid 19;
- Sustained positive outcomes for prison leavers;
- An expansion of community recovery coaches;
- The provision of an assertive outreach by local drug and alcohol services;
- Education and awareness in the community.

1.3 Recommendations and gaps in knowledge

i) Co-existing mental health problems

There remains a deep-rooted problem centred on 'dual diagnosis'. People with co-occurring substance misuse and mental health problems, at all levels of severity, face additional barriers in the access, take-up and outcome of treatment and support services. This is a complex issue. There is consensus on the importance of integration and closer multi-disciplinary working to tackle it, as well as an acknowledged difference in reporting/case management systems that services should communicate effectively so that any reporting differences do not create a barrier to communication.

Recommendations

1) Whilst there is broad consensus that there should be an integrated response to dual diagnosis, this needs to be explicitly and clearly articulated by senior managers; for example whether the ambition is the use of common assessment tools, common risk management, shared data systems, co-location of staff and agreed referral systems.

2) The importance of staff training and organisational cultures, across services and within a local area, has been emphasised by a number of partners. Services should be equipped and ready to respond pre-emptively, and not only to presenting issues.

3) A reemphasis on the important principles of a 'No Wrong Door' policy, and 'Making Every Contact Count'; that people with co-existing conditions can access support services (e.g. assessment, information, advice) which addresses their mental health and substance misuse needs in both alcohol/drug and mental health services. This also includes other drivers of morbidity and mortality, such as offering advice on smoking.

4) Use of diagnosis/es as exclusion criteria should be avoided and service redesign should be considered as an alternative to exclusion.

Known gaps in knowledge

1) Nationally (e.g. NICE NG58) we recognise that people with co-existing conditions are at higher risk of not using or losing contact with services. The number of individuals who have not been able to access or maintain engagement with local services for their needs, due to these reasons is unknown.

2) It is likely that persons within this cohort are at greater risk, due to further issues such as homelessness or abuse. Efforts are required to establish how we investigate and respond this. This will also aid our understanding of how co-existing conditions vary between and across groups and how vulnerabilities can be addressed.

3) Resultant demand across the system by this cohort is not locally known, for example the increased demand on emergency services, urgent care and criminal justice.

ii) Cumulative Problems and Holistic Approaches

The problem of less severe but cumulative problems, means that people can fall between services at an early stage. There is strong consensus that the needs of individuals should be addressed holistically. Our partners also raised issues in relation to some specific higher risk groups, such as younger adults, ex-offenders, and vulnerable groups such as those with a learning disability. The earlier problems can be identified the better, and a number of suggestions were made in relation to prevention and early identification.

Recommendations

1) Substance misuse difficulties and dependencies are not just an individual choice and issue to address, but part of a much wider social issue that requires a wider social (community) response.

At the community and population level, within local areas, further work is needed to challenge social/group norms relating to self-medicating with substances. This is vital to promote a healthier psychological environment, which acts to prevent problems developing and sustain recovery following treatment. This should include ongoing work to tackle denial, and stigma from engaging with support services.

2) Explore the development of early warning indicators (at an individual level) to identify escalating issues.

3) Strengthen working with the criminal justice system to ensure that pre-release interventions are in place; strengthening of prison to community protocols/procedures.

4) To take a holistic approach to individual circumstances, close working is needed at a local level, notably with children's social care, welfare benefit services, and housing providers. This was demonstrated by the positive feedback concerning close working across partnership as part of COVID homeless response. Links to the social prescribing workforce within primary care could also be explored.

5) Of note housing has been identified as a specific and rising concern (rising due to the predicted impact of Covid restrictions). The funding of specialist or dedicated housing advice staff should be considered.

Known gaps in Knowledge

1) Which local cohorts, beyond broad-level demographics, are driving the increase in alcohol related admissions/episodes? What are the options to tackle the chronic problem of people ending up in hospital from alcohol related problems? How do we understand and address escalating episodes from some residents, with reference to referral pathways into and from hospital settings?

2) What can health service commissioners and adult social care offer each other in terms of supporting older residents drinking at higher risk levels?

3) What are the patterns and volume of service delivery around alcohol brief-interventions and onward referrals, e.g. to treatment services? What are pros and cons in investigating how we might target evidence-based interventions - for example, where there are areas of high/higher hospital admissions?

4) What are the ongoing impacts for parents after planned exits, in terms of supporting them and their families?

iii) Improving Engagement with Service Users and Shared Decision Making

Whilst not higher than national levels, there are still significant numbers of unplanned exits from our services and deaths (from any cause) of those whilst engaged. On the other hand, many are spending six years or more engaged with opiate support services, and whilst this may be appropriate for those individuals, it is prudent to recommend a concerted effort for engagement to evidence improvements here and for elsewhere (i.e. in addressing co-existing conditions and better supporting those with housing problems or other vulnerabilities).

A number of comments were made by our partners which stressed the importance of working with people at different levels:

- at the individual level, in relation to promoting shared decision making between professional and service user;
- the importance of engagement with service users, individually and collectively to inform the development and delivery of services;
- and the need to work using strength-based and asset-driven approach within communities.

Recommendations

1) A commitment be made by local leaders to form a joint engagement plan, and to pursue, document and address the findings of different lines of engagement. This will include efforts to understand individual-level contexts and the personal or systemic drivers which lead to the observed outcomes; be they, for example, unplanned exits, increased vulnerabilities, or an unwillingness/inability to initially engage with services.

2) In addressing the findings of these lines of engagement local leaders should evidence how such knowledge has informed their activity at the service level, and our policies at the wider systems level.

3) Shared decision making should be captured and used by services and more widely in ongoing policy reviews to understand how such practices have impacted on outcomes, particularly in terms of harm reduction and longer-term recovery.

Known gaps in Knowledge

1) Addressing the above will require establishing how to locally balance solutions between psycho-social and clinical ways of working.

2) This will require a comprehensive understanding of community assets and how they have shifted (particularly in the near future), due to the impact of Covid-19 on vulnerable residents. Reviewing community level assets for individuals on a personal basis and checking these, over time will help us to understand the trends and current position.

3) It is important to utilise avenues from all partners; for example, in criminal justice or children's social care, to help fill in the gaps in knowledge for how to better proactively support those later identified in the statistics contained in this report.

2. Background and introduction

The UK Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care. In 2019 they published their recommendations to reducing drug misuse deaths:

“Every drug death is avoidable. However, the United Kingdom, and in particular Scotland, have amongst the highest drug death rates in Europe. The evidence we have heard leads us to conclude that UK drugs policy is failing.

“The rate of drug-related deaths has now risen to the scale of a public health emergency. In England in 2018 there were 2,670 deaths directly attributed to drug misuse, an increase of 16% since 2017—if other causes of premature death amongst people who use drugs were included, it is likely that this figure would approximately double.

“We recommend a radical change in UK drugs policy from a criminal justice to a health approach. A health focused and harm reduction approach would not only benefit those who are using drugs but reduce harm to and the costs for their wider communities. Responsibility for drugs policy should move from the Home Office to the Department of Health and Social Care.

“We recommend that the Government should consult on the decriminalisation of drug possession for personal use from a criminal offence to a civil matter. The Government should examine the Portuguese system, where decriminalisation was implemented as one part of a comprehensive approach to drugs, including improving treatment services, introducing harm reduction interventions, and better education, prevention and social support. Decriminalisation of possession for personal use saves money from the criminal justice system that is more effectively invested in prevention and treatment.

“Decriminalisation will not be effective without investing in holistic harm reduction, support and treatment services for drug addiction. Doing so would save lives and provide better protection for communities.

“Improving treatment: Evidence based guidelines for treating people with drug dependency do exist, but there is an unacceptable gap between best practice and what services are actually able to deliver to people, as well as wide variation.

“Many people using drug treatment services are growing older and living with complex illnesses. Those living with both addiction and underlying mental illness find it difficult to access adequate treatment and services.

“Drug treatment services have faced funding cuts of 27% over the past three years, at a time when costs are rising. Although our inquiry has focused on the harms caused by illicit drugs, dependency on prescription medicines is an emerging and worrying issue which requires greater attention from government.

“Reducing harm: Harm reduction interventions—including needle and syringe programmes, drug checking services, naloxone, drug consumption rooms and heroin assisted treatment—can all play an important role in preventing deaths amongst drug users as well as protecting their communities by reducing the harm from discarded syringes and drug related crime.

“We call on the Government to direct significant investment into drug treatment services as a matter of urgency, and to also make sufficient funding available to ensure that heroin assisted treatment, naloxone, and needle and syringe programmes are available. Drug consumption rooms should be piloted in areas of high need. There should be greater efforts to support those at higher risk, including people in prison and at the point of release from prison.

“Commissioning and the workforce: We recommend that the Government conduct a review of the commissioning of drug treatment services to consider how they should be strengthened to enable them to co-ordinate and deliver the much-needed improvements to drug treatment services as effectively as possible. The Government should also address the current and predicted future workforce shortfall.

“Comprehensive education, prevention and social support: The first priority in developing a comprehensive response to drugs must be to invest in existing drug treatment services and extend and develop harm reduction initiatives.

“The Government also needs to fund a comprehensive package of education, prevention and support measures focused both on prevention of drug use amongst young people, and on improving the life chances of people who are recovering from drug use.”

- Extract from, UK Parliament, [Health and Social Care Committee](#) (2019)

2.1 National policy

2.1.1 National drug misuse strategy

In 2017 the UK government launched their national drug strategy, in which they estimated the social and economic cost of drug supply in England and Wales to be £10.7 billion per year.¹⁴ The strategy's overall aims were to reduce all harmful drug misuse and improve the numbers of people who recover from their dependence. They highlighted an approach, grouped under four key themes:

1. **Reducing demand:** by preventing people becoming drug users in the first place and amongst those who do use drugs to reduce escalating use. The strategy focuses on a universal approach across the life course including supporting health care professionals through the Healthy Child Programme and supporting education. In addition to the universal approach, the strategy also highlights the need for a targeted action for high priority groups as identified locally, including vulnerable young people such as looked after children, those not in education employment or training, veterans and homeless groups. Additionally, the strategy highlights a need for a targeted approach for evolving and emerging threats.
2. **Restricting supply:** by targeting the criminals who seek to profit by tackling the production and distribution of drugs, investing in improving border detection, managing intelligence, reducing enablers of criminality (making money laundering harder, reducing bribery and corruption) and improving the approach to drug-related offending by using health-based, rehab interventions and encouraging drug testing on arrest to enable it to be incorporated into sentencing.
3. **Building recovery:** offering people with drug dependence the best chance of recovery by ensuring joint working with homeless/housing support service, criminal justice partners, mental health and employment services. Additionally, the strategy sets out a plan for establishing a Drug Strategy Board to use greater transparency and data on performance to support local action.
4. **Global action:** to lead and drive action on the global scale as it is in the UK's interest to reduce worldwide supply and demand. For example, the UK leads global response to New Psychoactive Substances.

¹⁴ Source: UK Home Office, [Drug Strategy 2017](#) (2017)

2.1.2 National alcohol strategy

It is of note that there is no current national alcohol strategy for the UK government, the last of which was published by the Home Office in 2012 under the Conservative-Liberal Democrat coalition and ran to 2015.¹⁵ In this report, the government pronounced that “Over the last decade, we have witnessed a dramatic change in people’s attitude to and the harms caused by, alcohol consumption” (p.6) and estimated that in a community of 100,000 people, each year:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.

The report outlined clear goals for the strategy:

“Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess. The outcomes we want to see are:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines;¹⁶
- A reduction in the number of people “binge drinking”;¹⁷
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.”

At a local level the government expected work to tackle harmful alcohol use to be led by Public Health departments, by Health and Wellbeing Boards and by Police and Crime Commissioners. They also cite the need for multi-agency working and the clear link between harmful alcohol use and poor mental health.

¹⁵ Source: UK Home Office, [The government’s Alcohol Strategy](#) (2012)

¹⁶ Taken to mean ‘No more regularly than 3 to 4 units per day for men and no more regularly than 2 to 3 units per day for women’.

¹⁷ Taken to mean ‘Measured by those who self-report drinking on their heaviest drinking day in the previous week more than 8 units per day for men and more than 6 units per day for women’.

2.2 Local priorities

The following outline the broader health and wellbeing priorities and the more immediate priorities of drug and alcohol commissioning leads, as of the time of writing.

2.2.1 Health and Wellbeing five-year plan

The West Sussex Health and Wellbeing board recently published their five-year plan to improve health outcomes and reduce inequalities across the county, taking the perspective of the whole lifecourse, where work is divided into three major themes: Starting Well; Living and Working Well; and Ageing Well.¹⁸ Starting Well covers the early years of life from pregnancy, birth, childhood, schooldays to young adulthood. Living and Working Well covers adulthood, the 'middle years', from leaving school/university to retiring, including working life. Ageing Well covers the later life, from retirement, approximately 65 years and above, to end of life. These are viewed with an aim for developing prevention of poor health and wellbeing, as opposed to treatment.

Alcohol and drug use is mentioned through the five year plan, in the context of improving health behaviours and reducing inequalities; at start of life, for children living in households of harmful alcohol and drug use; and for living well, in terms of health behaviours which may have contributed to the stall in increase in life expectancy.

2.2.2 Existing priorities for service leads

Service leads in West Sussex have previously identified for the Safer West Sussex Partnership a series of priorities for the year 2020/21.

1. Carry out a West Sussex drug and alcohol needs assessment study to inform future commissioning activity and partnership work to reduce the harms from alcohol and drugs.
2. Work together to deliver the multi-agency Reducing Drug Related Death action plan, building on the findings of the Drug Related Death Audit.
3. Expand the provision of Naloxone (the opiate antidote) to a broader range of settings, including a scheme to distribute through pharmacies.
4. Understand more about the best ways to help people who are sleeping rough to have improved access to health services, through the delivery of the Hospital Admission Reduction Pathway (HARP) project, which is funded by Public Health England and designed

¹⁸ Source: West Sussex Health and Wellbeing Board, [Start Well, Live Well, Age Well: West Sussex Joint Health and Wellbeing Strategy, 2019-2024](#) (2019)

to support homeless or insecurely housed adults who have substance misuse and co-occurring mental health needs.

5. Improve joined up/multi agency working, particularly to engage and effectively support adults who have substance misuse and co-occurring mental health needs in order to meet their treatment and support needs.
6. Carry out analysis of the size and scale of the illegal drugs market in a local town in order to better understand the demand and supply, and to create sustainable, multi-agency interventions, using a public health approach.

2.3 Aims and objectives

2.3.1 Purpose of the report

This report is a part of the Joint Strategic Needs Assessment for West Sussex so contains information for system-wide plans, including CCG commissioners, partnership leads, and all those concerned with drug and alcohol use, community safeguarding, population health, policing and adult and children's social care. Its purpose is to provide the reader with an up to date summary of substance misuse issues in West Sussex, including figures on vulnerable populations and health-outcomes, particularly pertaining to wider social determinants and other drivers of poor health seen in the literature, and has been requested by local substance misuse commissioners to support decisions taken in the planning, commissioning, and provision of services.

2.3.2 Oversight of the needs assessment

From the outset, a reference group helped advise on the content and format of the needs assessment. This group included Public Health consultants and a PHE Registrar, the Public Health Lead for substance misuse, the Senior Commissioning Manager for substance misuse, and the Principal Manager of the Public Health and Social Research Unit at West Sussex County Council. Executive oversight was provided by the Director of Public Health and Safer West Sussex Partnership, who, with the West Sussex Health and Wellbeing Board, will be responsible for overseeing partnership work to improve outcomes for residents and cohorts identified. These included Community Safety Partnership leads for all unitary authorities, Sussex Police, Adults and Children's Social Care, and representatives from numerous local safeguarding boards.

2.3.3 Timelines and data sources

The project, originally outlined at the beginning of 2020 and conducted throughout the year, includes a review of available literature, with relevant local and national guidelines. Quantitative data was collected from a range of sources, but primarily focused on PHE Outcome Indicators

(PHE Fingertips) and National Drug Treatment Monitoring System (NDTMS) service data, due to their consistent figures allowing for comparisons and monitoring over time. These were collected to the most recent available full year published, though some data sources have longer time-lags in publication. As such, some data are only captured up to 2018/19. Continued monitoring of these by the Joint Commissioners and Public Health teams mean that strategic decisions can always use the most up to date data available.

2.3.4 Health Needs Assessment Structure

In comprehensive health needs assessments, there is an element of boundary work, to identify what is in and out of scope. It is important to note that descriptions of vulnerabilities and issues are placed under discrete chapters and headings in order to improve readability. For example, whilst Section 4 refers to 'prevalence and high-risk groups', these are often discussed in series, as discrete cohorts.

It is important therefore to stress that many issues are experienced in any number of combinations for different individuals. Risk factors tend to cluster in real people's lived experiences and support should be designed and delivered with that in mind. Similarly, little mention is made of these cohorts in Sections 5 and 6, which refer to the outcomes of substance misuse and the journey taken with treatment services. Whilst it is possible and practical to refer to a single Section as a catalogue of data, a reader may find benefit in referring to other Sections to understand wider related issues and how these can intersect in individuals' lives. The report structure is outlined in Section 1, for ease of navigation.

Background and Information, Key summary:

In 2019, the UK Health and Social Care Committee, recommended a radical change in UK drugs policy moving from a criminal justice to a health approach, where responsibility for drugs policy rests with the Department of Health and Social Care and not the Home Office.

The Committee recommended a comprehensive approach to drugs, including improving treatment services, introducing harm reduction interventions, and better education, prevention and social support. The Committee noted that while evidence-based guidelines for treating people with drug dependency do exist, there is an unacceptable gap between best practice and what services are actually able to deliver to people, as well as wide variation. They called on the government to direct significant investment into substance misuse treatment services.

In 2017, the UK government launched the national drug strategy, in which they estimated the social and economic cost of drug supply in England and Wales to be £10.7 billion per year.¹ The strategy was framed around several themes, including: Reducing demand; Restricting supply; Building recovery; and Global action. There is no current national alcohol strategy, but in the previous strategy (which ran to 2015) the government anticipated that work to tackle harmful alcohol use be led by Public Health departments, Health and Wellbeing Boards and Police and Crime Commissioners. They also cited the need for multi-agency working and the clear link between harmful alcohol use and poor mental health.

Alcohol and drug use is mentioned throughout the West Sussex Joint Health and Wellbeing Strategy in the context of improving health behaviours and reducing inequalities; at start of life, for children living in households of harmful alcohol and drug use; and for living well, in terms of health behaviours which may have contributed to the stall in increase in life expectancy.¹

The Safer West Sussex Partnership has a series of priorities for the year 2020/21 in the refreshed Safer West Sussex Partnership Community Safety Agreement 2016-2020, including this needs assessment; a multi-agency Reducing Drug Related Death action plan, building on the findings of the Drug Related Death Audit; expanding the provision of Naloxone; supporting those with homelessness/housing issues to improve health outcomes; supporting those with co-existing mental health and substance misuse issues; and to carry out analysis of the size and scale of the illegal drugs market in a local town in order to better understand the demand and supply.

This needs assessment, via a range of methods and data sources, aims to provide service commissioning leads, executive boards, and providers with the detailed analysis they require to continue to support those with substance misuse issues, both directly and indirectly.

3. Local Context

This first data section describes the local population characteristics relevant to the rest of the document, where county and district-level data are often used. Reviewing later sections back to this population summary should give a clearer picture of how issues can affect some communities or cohorts more than others and aid local targeted approaches.

Key headings:

- 3.1 Population and geography
- 3.2 Population demographics
- 3.3 Multiple Deprivation and local inequalities

3.1 Population and geography

West Sussex is a large and diverse county, covering over 750 square miles and home to over 850,000 people¹⁹. Around 86% of this area is classed as rural and 14% as urban. In 2011, 192,000 people lived in these rural areas (24%), with 615,000 living in urban areas (76%), compared to 20% rural and 80% urban for the South East as a whole. The population density of urban land is around 22 people per hectare, compared to just one person per hectare for rural land, on average.²⁰ There are five districts and two urban boroughs in the county, with much of the population living on the South coast or in the North East, divided by the rural South Downs national park. Rail lines connecting the coast to Gatwick and London in the East and in the north have led to modern population growth in the Mid Sussex and Horsham districts.

3.2 Population demographics

Due to limited alternative sources, much of the population data are taken from the 2011 UK census, as and such may not fully depict the current population. Population estimates from the ONS are used where available.

In 2018, 858,850 people were estimated to reside in West Sussex. This was 6,500 more than 2017, an increase of 0.8%. The year-on-year growth in West Sussex was slightly higher than the national rate (0.6%), in line with CIPFA comparable authorities (average 0.7%). In terms of STP, this is similar compared with Brighton and Hove (0.8%) and higher than East Sussex (0.4%). The year-on-year growth in Horsham was one of the highest in South East (after Dartford and Wokingham).

¹⁹ Source: ONS, population projections, (2018)

²⁰ Source: ONS, UK census (2011); a hectare is equal to an area of one hundred by one hundred metres.

Table 3.1, West Sussex 2018 population

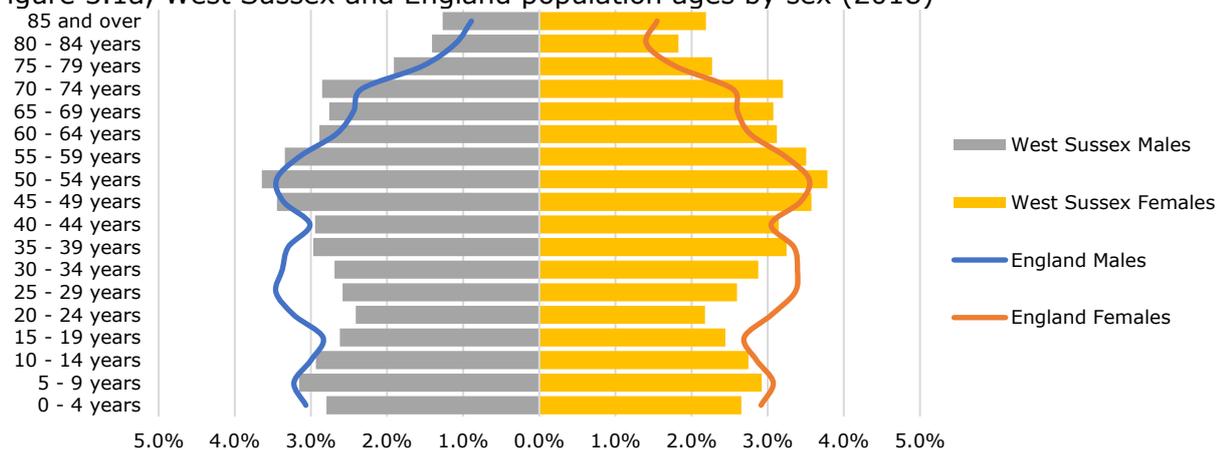
Population	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing	WEST SUSSEX
2017	63,720	158,660	120,190	111,660	140,140	148,350	109,630	852,350
2018	63,870	159,830	120,750	112,450	142,220	149,720	110,030	858,850
Change	150	1,170	560	790	2,080	1,370	400	6,500
% Change	0.2%	0.7%	0.5%	0.7%	1.5%	0.9%	0.4%	0.8%

Source: ONS Population projections (2019)

3.2.1 Age distribution

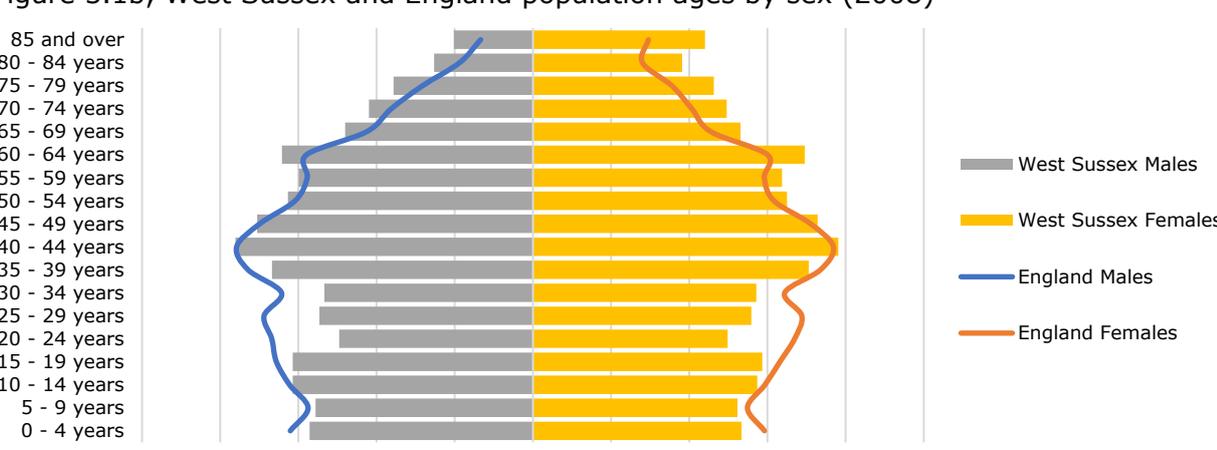
The age distribution of West Sussex residents is older than the England population, with more individuals aged over 50 years and fewer individuals aged 15-39 years. Twenty two percent of residents are aged over 65 years, compared with 19% in the South East and 18% in England. Overall, the West Sussex population structure is changing at a similar rate to England as a whole, with an increase of the proportion of over-65s from 20.2% to 22.8%, from 2008 to 2018 (16.0 to 18.2 for England).

Figure 3.1a, West Sussex and England population ages by sex (2018)



Source: ONS Population projections (2019)

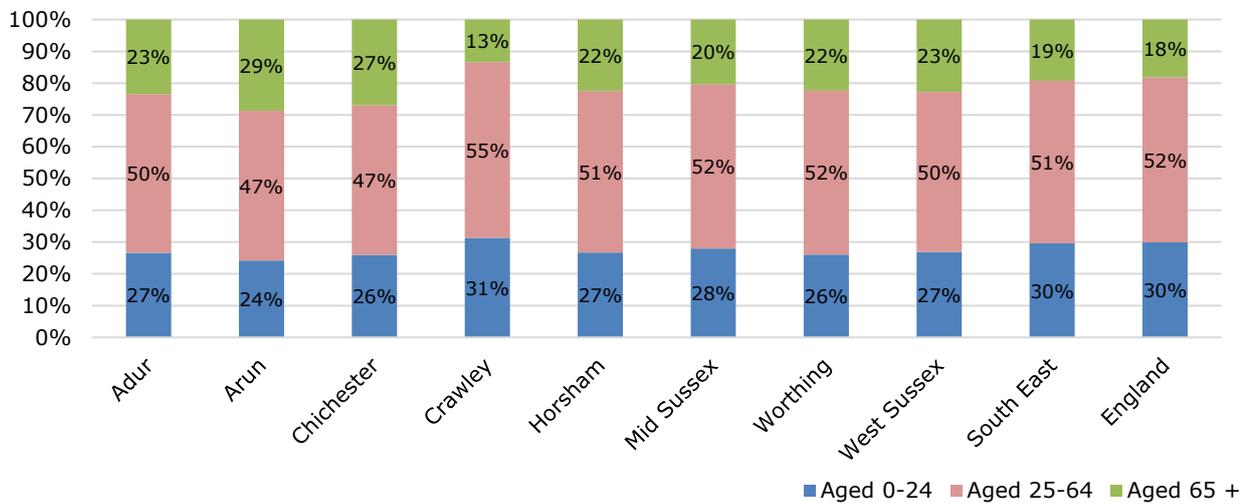
Figure 3.1b, West Sussex and England population ages by sex (2008)



Source: ONS Population projections (2019)

Locally, Crawley Borough is a notable exception in West Sussex, with an age structure younger than that of the national average. Arun and Chichester Districts have the largest proportion of residents aged over 65 years.

Figure 3.2, Age bands of West Sussex areas (2018)



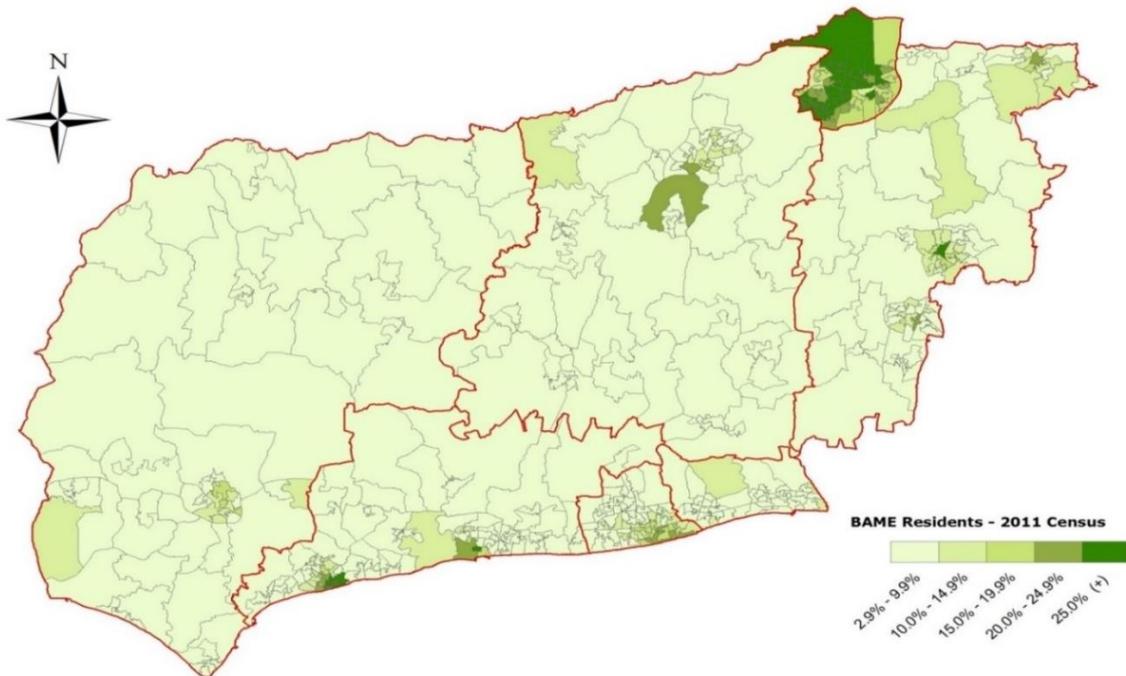
Source: Nomis (ONS population projections)

3.2.2 Ethnicity and nationality distribution

Minority ethnic and first-generation migrant (i.e. those born outside the UK) communities in West Sussex are more prevalent in Crawley Borough, where they accounted for 28% of the population in 2011 (also higher than the national averages of 20%). Elsewhere in the county, this ranged from around 7-10% of residents, many of which include Eastern European families, of which Polish is the largest single country of birth. Residents born abroad are more likely to be aged between 25-64 than UK-born residents.²¹

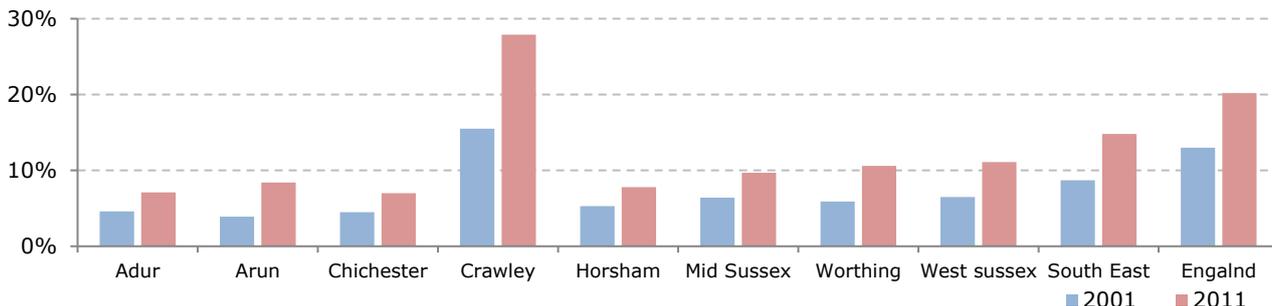
²¹ More details on the West Sussex BAME population are contained in a separate [Needs Assessment](#) (2016)

Figure 3.3, West Sussex BAME populations, as a percentage of all residents



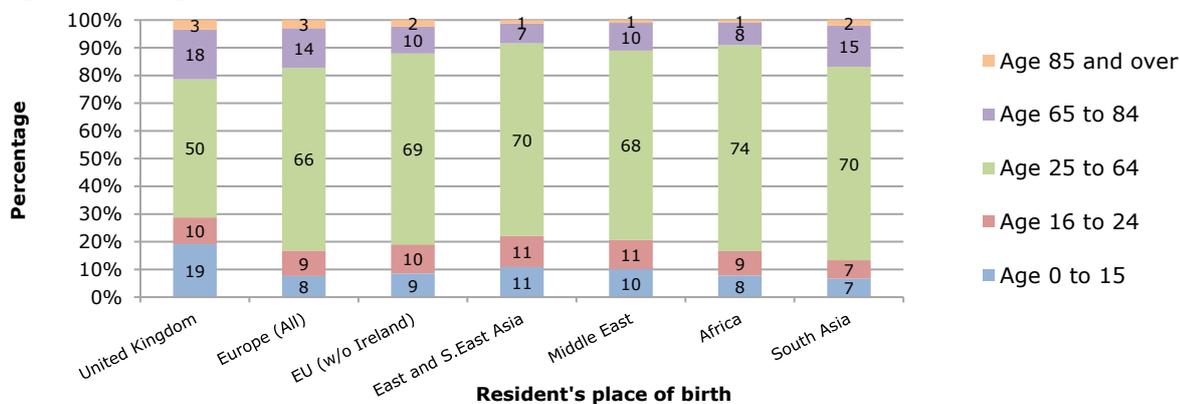
*Includes 'White Irish', 'Gypsy/Traveller' and 'White Other' as defined by the 2011 census
 Source: West Sussex PHSRU, using ONS, 2011 Census, at Lower Super Output Area (LSOA)

Figure 3.4, BAME composition by West Sussex unitary authority, from 2001-2011



*Includes 'White Irish', 'Gypsy/Traveller' and 'White Other' as defined by the 2011 census
 Source: West Sussex PHSRU, using ONS, 2011 Census

Figure 3.5, Age breakdown of West Sussex residents by their place of birth



Source: West Sussex PHSRU, using ONS, 2011 Census

The range of main language spoken in West Sussex is extensive. Twenty one languages were recorded as spoken by at least 500 people across the county. A further 19 languages are spoken by at least 100 people. In Crawley, 13% of residents do not use English as their main language. Polish is the most widely spoken main language in West Sussex, with nearly as many as the next four languages combined.

Table 3.2, Main languages spoken in West Sussex by at least 500 people

Main Language	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
All residents aged 3+ years	779,010	59,050	145,040	110,445	101,600	127,080	134,945	100,850
English (English Percentage)	742,040 95.25%	57,620 97.58%	138,320 95.37%	107,370 97.22%	88,305 86.91%	123,650 97.30%	130,305 96.56%	96,470 95.66%
Polish	6,300	135	2,545	650	1,670	325	450	525
Portuguese	1,955	35	450	150	960	75	135	145
Gujarati	1,650	25	50	40	1,355	35	85	65
Tagalog/Filipino	1,500	20	195	135	165	260	380	345
Urdu	1,440	10	35	15	1,230	40	55	55
French	1,435	75	145	155	420	220	265	150
Lithuanian	1,320	-	525	85	415	35	35	220
Tamil	1,310	5	50	25	1,035	25	90	80
Bengali	1,225	140	185	75	270	80	160	315
Spanish	1,185	60	125	140	300	180	240	145
German	1,045	60	155	195	120	145	260	115
Italian	1,005	45	65	70	255	155	180	235
Hungarian	920	35	135	45	340	160	150	55
Russian	895	40	360	75	175	60	85	105
Malayalam	750	10	90	80	70	140	285	75
Arabic	700	160	55	40	250	50	50	95
Panjabi	650	10	5	-	580	20	15	20
Latvian	630	15	320	40	160	20	35	40
Romanian	620	15	105	50	165	125	120	40
Slovak	580	15	70	45	195	95	85	75
Turkish	540	35	75	40	130	35	105	115

*In the UK national census, 'main language' is not tightly defined, but respondents are asked "What is your main language?" and are supplied with a free-text response box to enter their answer.

Source: West Sussex PHSRU, using ONS, 2011 Census

3.3 Multiple Deprivation and local inequalities

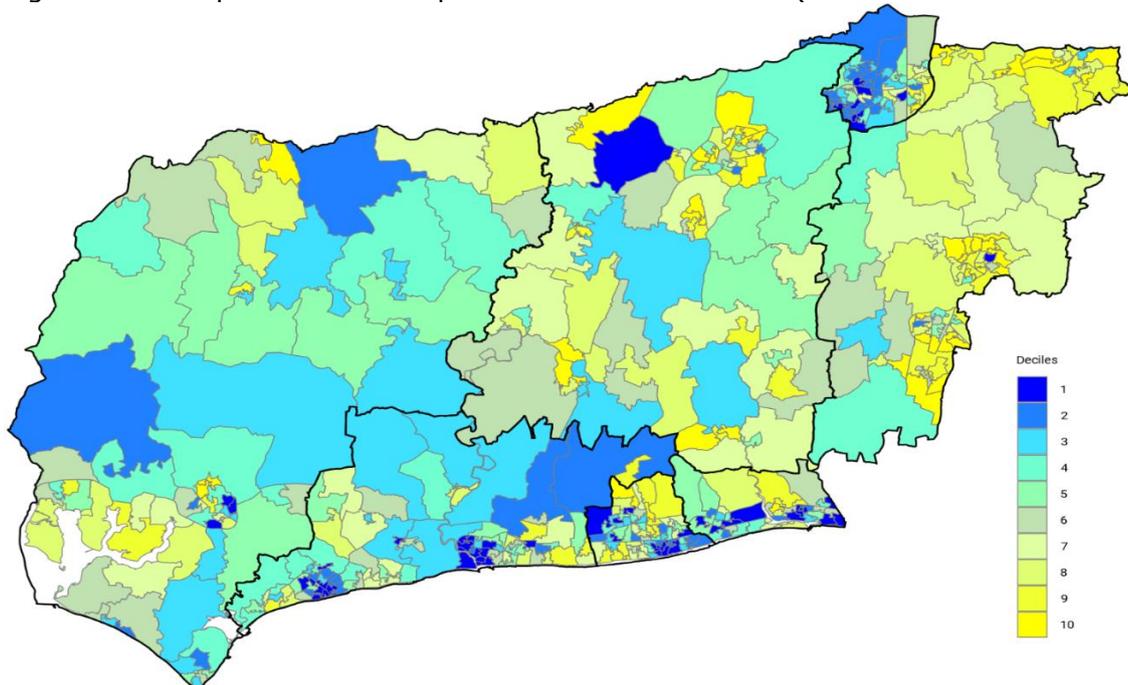
There are many wider societal determinants which are associated in heightened risk of drug or alcohol dependence. Social factors, including housing, employment and deprivation, are associated with substance misuse and these social factors moderate drug treatment outcomes. Being in education or employment and being in good physical health can increase the chances of successful substance misuse treatment, whilst substance misuse can also impact on education, employment and health. Having housing problems or living in an area of higher deprivation can reduce the chances of successful treatment.²² There are several ways to examine these levels of deprivation, relative to other areas in the local authority.

²² Source: PHE, [Health matters: preventing drug misuse deaths](#) (2017)

3.3.1 Index of Multiple Deprivation (IMD2019)

The Index of Multiple Deprivation (2019) combines information from seven domains to produce an overall relative measure of deprivation.²³ In 2019, West Sussex ranked 129th of 151 upper tier authorities (1 being most deprived, 151 being least deprived). Overall, the county remains one of the least deprived areas in the country. In relation to neighbouring authorities, West Sussex is relatively less deprived than East Sussex (ranked 93rd) and Brighton and Hove (ranked 87th); and more deprived than Hampshire (ranked 136th) and Surrey (ranked 145th). Ranking values for Clinical Commissioning Group areas were also published. Of the 191 CCGs of 2019, Coastal West Sussex CCG ranked 139th, Crawley CCG 95th and Horsham and Mid Sussex CCG ranked 189th.

Figure 3.6 Multiple combined deprivations in West Sussex (IMD 2019 internal deciles)



*Dark blue represents higher relative deprivation for this domain, yellow represents lower deprivation
Source: West Sussex PHSRU, using ONS data (IMD 2019 release)

Using national rankings to understand deprivation can mask internal inequalities, however. Using internal rankings of all neighbourhoods (LSOAs²⁴) commissioning leads can target local areas where specific domains of deprivation are higher. Overall, urban areas of the coastal strip; Bognor Regis, Littlehampton, Worthing and Shoreham, and Western Crawley, have higher relative

²³ The domains are combined by ONS using the following weights: Income Deprivation (22.5%), Employment Deprivation (22.5%), Education, Skills and Training Deprivation (13.5%), Health Deprivation and Disability (13.5%), Crime (9.3%), Barriers to Housing and Services (9.3%), Living Environment Deprivation (9.3%). The weights have been derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators.

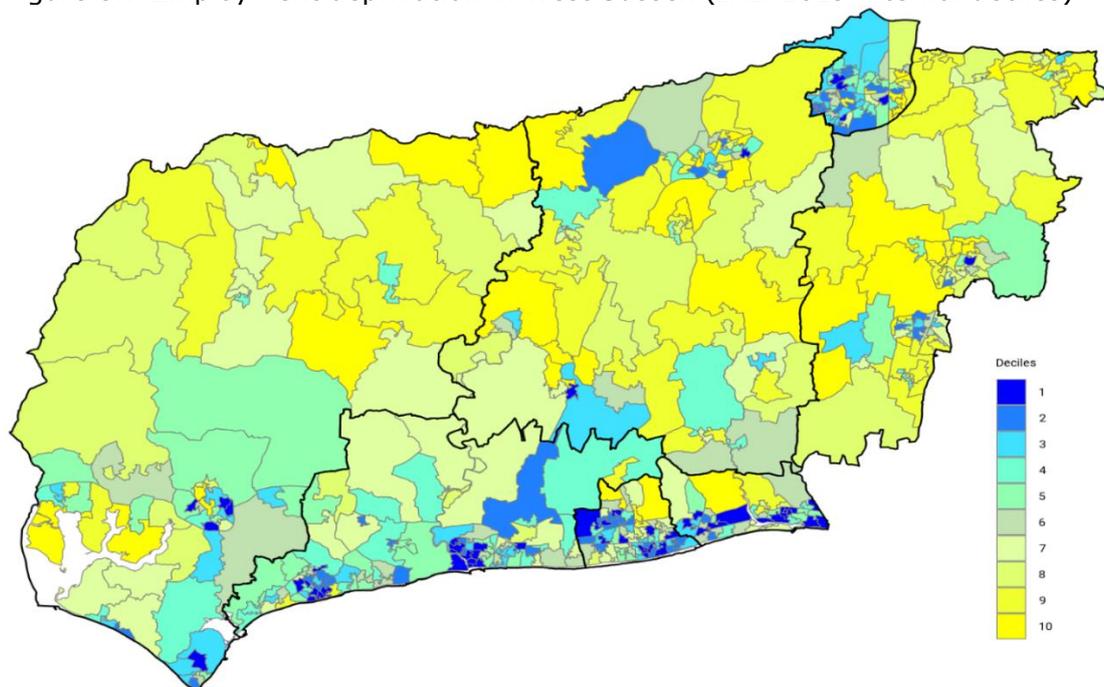
²⁴ Lower Super Output Areas are fixed geographies of between 400 and 1,200 households.

deprivation compared to other areas of the county and several areas of Arun district are amongst the most deprived areas of England.²⁵

3.3.2 Employment Deprivation

The Employment Deprivation Domain measures the proportion of the working age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities. Locally, the more urban areas of the coastal strip and Crawley carry consistently high levels of deprivation, though other towns, including Chichester, Selsey and Horsham also have localised deprivation in the highest quintile. Employment has been linked to successful opiate treatment and getting unemployed drug and alcohol service users back into employment is a key performance measure for local services.²⁶

Figure 3.7 Employment deprivation in West Sussex (IMD 2019 internal deciles)



*Dark blue represents higher relative deprivation for this domain, yellow represents lower deprivation
Source: West Sussex PHSRU, using ONS data (IMD 2019 release)

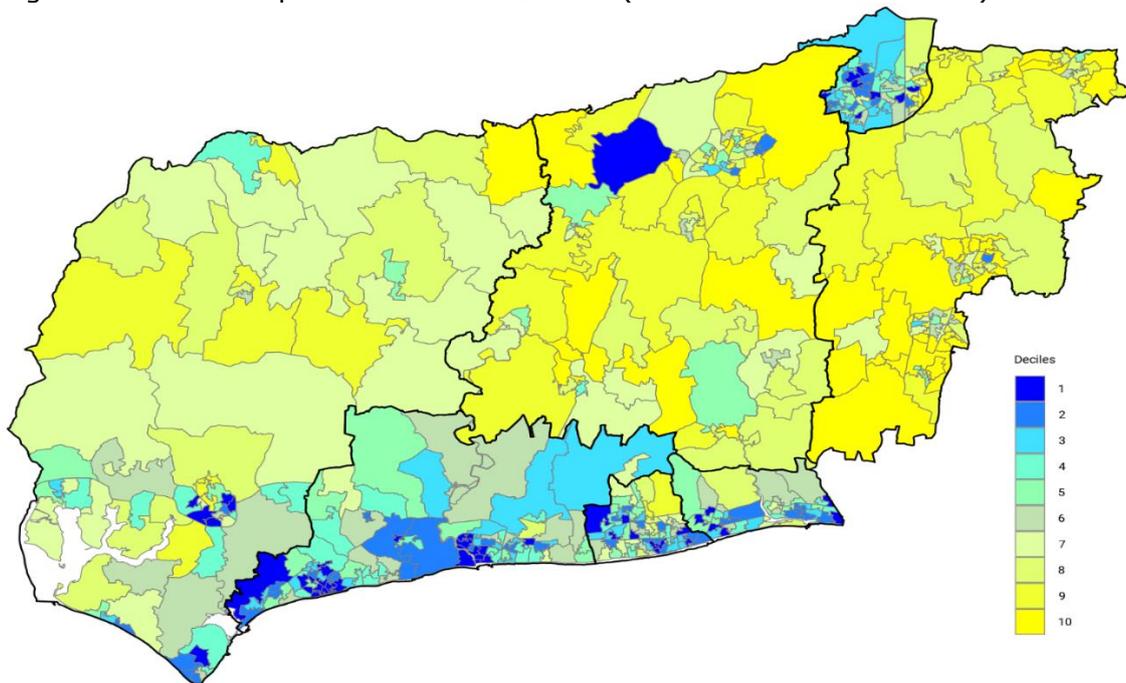
²⁵ Courtwick with Toddington, Marine and Bersted (Arun), and Broadfield South (Crawley) contain neighbourhoods in the 10% most deprived areas of the country: [PHSRU analysis of ONS IMD \(2019\)](#)

²⁶ Source: PHE, [An evidence review of the outcomes that can be expected of drug misuse treatment in England](#) (2017)

3.3.3 Health Deprivation and Disability

The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation. Throughout this report, the two-way link between poor health and substance misuse is explored.

Figure 3.8 Health deprivation in West Sussex (IMD 2019 internal deciles)



*Dark blue represents higher relative deprivation for this domain, yellow represents lower deprivation
Source: West Sussex PHSRU, using ONS data (IMD 2019 release)

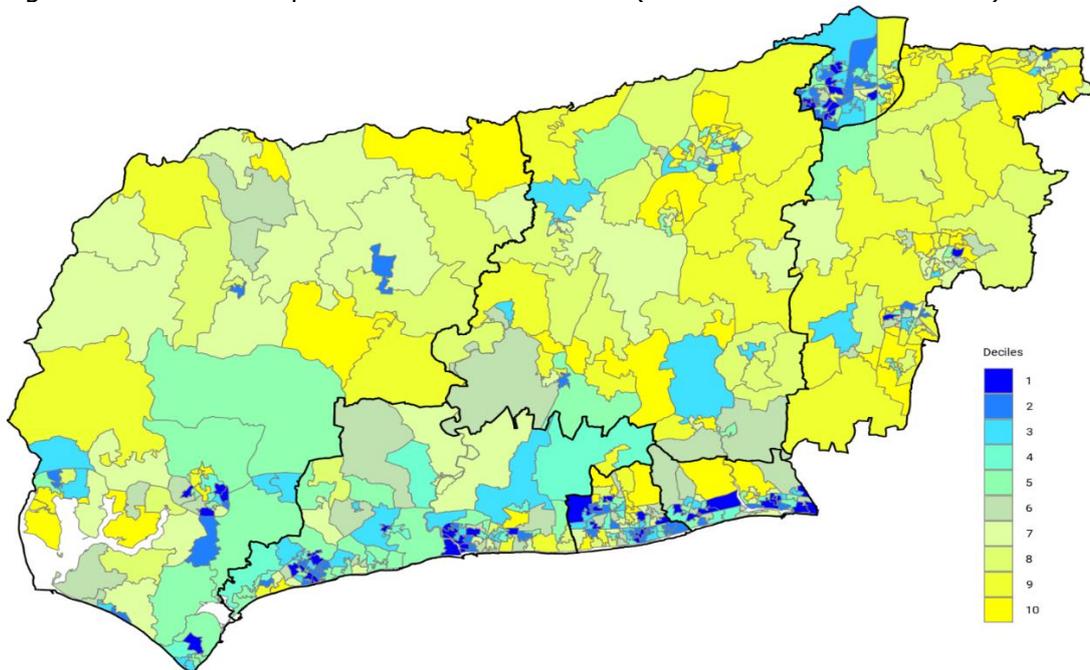
3.3.4 Income Deprivation

The Income Deprivation Domain measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out- of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

At the time of writing this needs assessment the UK is still working to manage the COVID-19 pandemic. In addition to the health impact of COVID-19, there are wide range socio-economic impacts, yet to be fully understood or realised. There are areas of West Sussex, such as Crawley, that have been identified as being particularly at risk of a continued economic downturn in the short to medium term, in part due to the importance of Gatwick airport as a local employer.

We also know that there is a strong social gradient in the ability to mitigate the impact of the pandemic at a personal, family and community level, this will act to widen existing inequalities within the county.

Figure 3.9 Income deprivation in West Sussex (IMD 2019 internal deciles)



*Dark blue represents higher relative deprivation for this domain, yellow represents lower deprivation
Source: West Sussex PHSRU, using ONS data (IMD 2019 release)

Local Context, Key Summary:

West Sussex has roughly 860,000 residents and overall, the county has an older age profile than the national average. Crawley is an exception, with a younger age profile than England.

West Sussex has a lower Black, Asian and Minority Ethnic (BAME) population than the South East, with 88% of residents identifying as White British in 2011. Crawley is an exception, where 72% identify as White British. BAME residents are known to face different barriers to services and health inequalities have been documented.

Wider determinants of health and social inequalities are known to be linked with substance misuse, accessing services and improved treatment outcomes. Each district and borough has some areas of higher deprivation, though these are more consistently focused in the urban areas of the coastal strip and in west Crawley. Due to the range of social determinants, partnerships made up of a range of organisations are needed to address underlying drivers of substance misuse issues.

In addition to the health impact of COVID-19, there are wide range socio-economic impacts, yet to be fully understood or realised.

4. Prevalence in The Community and Higher Risk Groups

This section covers the local scale of alcohol and substance misuse in West Sussex and using a range of data sources these include both estimates and observed incidence.

Key headings:

- 4.1 Alcohol misuse in the general population
- 4.2 Drug misuse in the general population
- 4.3 Families and substance misuse
- 4.4 Young people and substance misuse
- 4.5 Substance misuse amongst sex workers
- 4.6 Exploitation through county lines and modern slavery
- 4.7 Homelessness and housing issues
- 4.8 Learning disabilities

4.1 Alcohol misuse in the general population

4.1.1 Estimated prevalence

The estimated number of people with alcohol dependence in West Sussex is calculated by NDTMS, based on modelled estimates of use in the population at the local authority level.²⁷ These estimates leave wide margins of certainty, displayed in Table 4.1. In West Sussex, there are approximately 7,000 residents with alcohol dependence.

Table 4.1, Estimated population of West Sussex in need of specialist alcohol treatment

Period	Estimated prevalence	Lower bound (95%)	Upper bound (95%)
2014/15	6,966	5,335	9,499
2016/17	7,096	5,543	9,296
2017/18	7,071	5,557	9,349

Source: NDTMS

There are however no national estimates for harmful drinking under this level of dependence. The Public Health England: Risk Factors Intelligence (RFI) team have used data from the Health Survey for England, collected between 2011 and 2014, to estimate²⁸ that: 24% of adults in West Sussex are drinking above the lower risk limits of 14 units per week (approximately 165,000 people), and 14% of adults engaged in binge drinking on their heaviest drinking day in the past week (approximately 96,000 people).²⁹

²⁷ Source: University of Sheffield and King's College, London: [Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence: Prevalence, Trends, and Amenability to Treatment](#) (2017)

²⁸ Source: NHS Digital (2020)

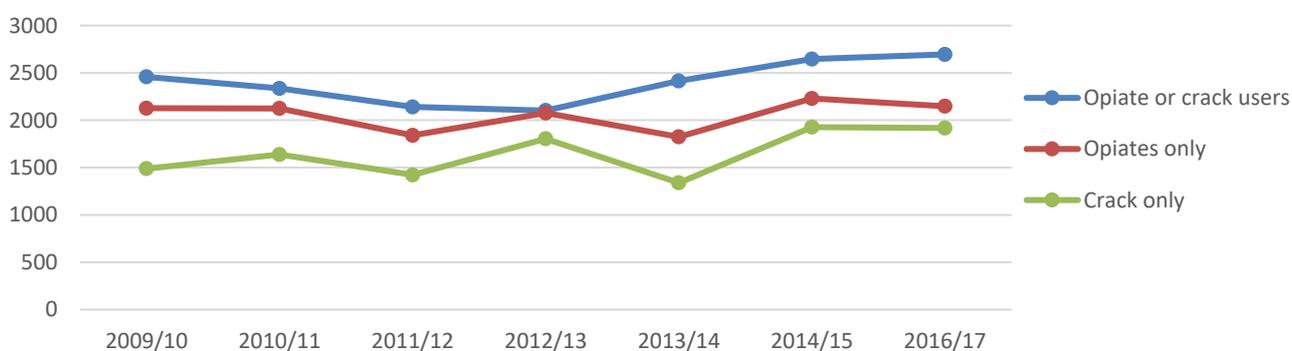
²⁹ Source: From ONS population projections (2018); of the 860,000 residents estimated to live in West Sussex roughly 690,000 are aged 18 or over, which provides our denominator.

4.2 Drug misuse in the general population

4.2.1 Estimated prevalence

The estimated number of opiate and / or crack users (OCUs) in West Sussex is calculated by NDMS, based on modelled estimates of use in the population at local authority level.³⁰ These prevalence estimates give an indication of the number of OCUs in each local area that are in need of specialist treatment; confidence intervals for these are wide, which makes tracking trends over time difficult. It is necessary then to rely on proxy indicators and mapping of wider inequalities to help communities and ensure access to services is as streamlined and barrier-free as possible. The point estimate for opiate use in 2016/17 (2,150), for example, ranged from 1,200 to 3,120 individuals.

Figure 4.1, Estimated population of West Sussex in need of specialist opiate or crack treatment



*Point estimates without confidence intervals.

Source: NDMS

4.2.2 Public drug use and litter

Using data collected by District and Borough councils it is possible to map some of the drug activity in public spaces; i.e. public toilets, carparks, streets and green spaces. Data for these are incomplete and do not represent all public drug use or all observed litter, however over the past several years, thousands of pieces of drug-related litter have been identified by local councils. With improved data recording and sharing it would be possible to track this over time. Identifications are more common in summer months (35% of all annual findings) and tend to exist more in urban areas. The table below shows incomplete data, but a considerable amount of activity has been identified in Worthing and Adur. – Up to date data are currently held by the WSCC Community Safety and Wellbeing team.

³⁰ Source: PHE, PHI and Liverpool John Moores University: [Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2016/17: Sweep 13 report](#) (2019)

Table 4.2, Number of pieces of drug litter identified by Districts and Boroughs in West Sussex

Year	Adur & Worthing	Arun	Chichester	Crawley	Horsham	Mid Sussex	West Sussex
2020	327	*	24	74	*	2	427
2019	672	*	125	425	170	5	1,397
2018	475	117	134	403	*	*	1,129
2017	106	35	35	274	*	*	450
2016	94	*	*	18	*	*	112

*Missing data

Source: WSCC Community Safety and Wellbeing team (2020)

Of the 3,500 pieces of litter identified, roughly half were syringes, barrels and needles, with the next most common being the small plastic bags often used to hold drugs. Recently there have been local concerns, particularly in Adur and Worthing over the use of Nitrous Oxide (N₂O) which can be inhaled from small pressurised canisters that are single-use and so discarded at the site.³¹ From September 2018 to August 2020 (representing the last two complete years of data) there were 235 instances of pressurised canisters being found in public within the Adur and Worthing area. This accounts for 89% of all canister findings in West Sussex in the same period, though the incomplete data may not represent the true activity.

Table 4.3, Count of types of drug-related litter identified in West Sussex (*2020 incomplete)

Type of material/litter identified	2016	2017	2018	2019	2020	Total
Drinks cans or foil containers, may be discoloured by heat	2	22	28	14	7	73
Spoons – burnt or discoloured by heat		11	81	55	20	167
Pipes, all shapes, sizes and materials		1	7	10	5	23
Cigarette papers or ripped packs		1	15	22	4	42
Foil with burn mark down the middle		8	14	12	6	40
Shredded cigarettes		24	2	10	5	41
Squares of paper (folded to form a small envelope)			4	18	8	30
Syringes, barrels and needles	101	317	550	621	164	1,753
Plastic bags, corners of plastic bags, small 'Ziplock' bags	2	21	263	388	49	723
Aerosols butane gas, nitrous oxide canisters		17	63	123	106	309
Small phials and bottles		1	23	34	5	63
Small, colourfully 'branded' packets used to hold NPS			65	68	33	166
Small foil water dishes for preparing injections			4	14	3	21
Cannabis plants / residue	3	3	2	1	2	11
Sharps Box	1		7	2		10
Miscellaneous / other	3	24	1			28
Unknown / uncoded				5	10	15
Annual total	112	450	1,129	1,397	427	3,515

Source: WSCC Community Safety and Wellbeing team (2020)

³¹ Pressurised canisters can include butane gas and other solvents which are inhaled and are not limited to Nitrous Oxide alone. Habitual abuse of Nitrous Oxide can lead to B-12 vitamin deficiencies which affect the brain and nervous system.

4.3 Families with substance misuse

The impacts of substance use on family members can range from having unmet developmental needs, impaired attachment to economic hardship and sometimes violence perpetrated against them, for children there is an additional risk of developing their own substance misuse problem.

An estimated 41% of pregnant women in the UK drink during pregnancy, despite Chief Medical Officer guidance stating that no levels of alcohol consumption are safe during pregnancy. Heavy drinking can cause foetal alcohol spectrum disorder, a term that encompasses a range of alcohol-related birth defects, which can manifest as learning difficulties, mood, attention or behavioural problems, poor physical growth and often distinctive facial features, the severity of symptoms varies and it is often under-diagnosed and so many people are not receiving the support they need, estimates have been put as high as 32/1,000 live births.

Parents who have drug or alcohol use problem may experience poor physical and mental health, difficulties securing and sustaining employment and housing and increased crime. All these factors can considerably impact on their family life and children. Between 2011 and 2014 parental alcohol misuse was implicated in 37% of cases that involved the death or serious injury of a child through neglect or abuse; drug use in 38% of cases; and either drugs or alcohol in 47% of cases.³²

4.3.1 Alcohol

PHE estimate that there are 2,700 children in West Sussex living with an adult with alcohol dependency.³³ This is compared to the 375 children known to live with an adult who entered alcohol treatment in 2019/20. Over half of alcohol service admissions are parents or live with children. Thirty percent of new alcohol service users in 2019/20 lived with a child and a further 29% had children with whom they did not live. More females lived with the children than males, but overall numbers are relatively equal between males and females. Of new female alcohol service users, 2% were pregnant at the time, which is comparable to national figures (1%).

Table 4.4, Parental status of new service users for alcohol treatment, in West Sussex 2019/20

Parental status	Number new presentations	Proportion of new presentations	Proportion by sex	
			Male	Female
Living with children (own or other)	205	30%	23%	39%
Parent not living with children	197	29%	32%	24%
Not a parent/no child contact	280	41%	44%	37%
Total	724	100%	100%	100%

Source: PHE, West Sussex Adults - alcohol commissioning support pack 2021-22: key data

³² PHE: [Parental alcohol and drug use: understanding the problem](#) (2018)

³³ Source: PHE, [Problem parental drug and alcohol use: a toolkit for local authorities](#) (2018)

The demand on Children’s services can be impacted also, with 17% of the alcohol service users who have, or live with, children who are involved with Children’s social care services, such as Early Help (5%) or a child protection plan in place (6%).

Table 4.5, Alcohol service users with children receiving early help or in contact with children's social care, 2019/20

Contact with Children’s services	Number of service users	Proportion of service users with child contact
Early help	20	5%
Child in need	7	2%
Child protection plan in place	25	6%
Looked after child	7	2%

Source: PHE, West Sussex Adults - alcohol commissioning support pack 2021-22: key data

4.3.2 Drugs

In West Sussex, 415 children lived with an adult who entered drug treatment in 2019/20. Over half of drug service admissions are parents or live with children. Twenty five percent of new drug service users in 2019/20 lived with a child and a further 30% had children with whom they did not live. Female service users were more likely to live with the child in question. Of new female drug service users, 6% were pregnant at the time, which comparable to national figures (4%).

Table 4.6, Parent/carer status of new service users for drug treatment, in West Sussex 2019/20

Parental status	Number new presentations	Proportion of new presentations	Proportion by sex	
			Male	Female
Living with children (own or other)	226	25%	23%	29%
Parent not living with children	273	30%	30%	31%
Not a parent/no child contact	404	45%	47%	39%
Total	928	100%	100%	100%

Source: PHE, West Sussex Adults - drugs commissioning support pack 2021-22: key data

The demand on Children’s services can be impacted also, with 23% of the drug service users in contact with children also involved with Children’s social care services, such as Early Help (3%) or there being a child protection plan in place (13%).

Table 4.7, Drug service users with children receiving early help or in contact with children's social care, 2019/20

Contact with Children’s services	Number of service users	Proportion of service users with child contact
Early help	14	3%
Child in need	16	3%
Child protection plan in place	63	13%
In the care of the local authority	20	4%

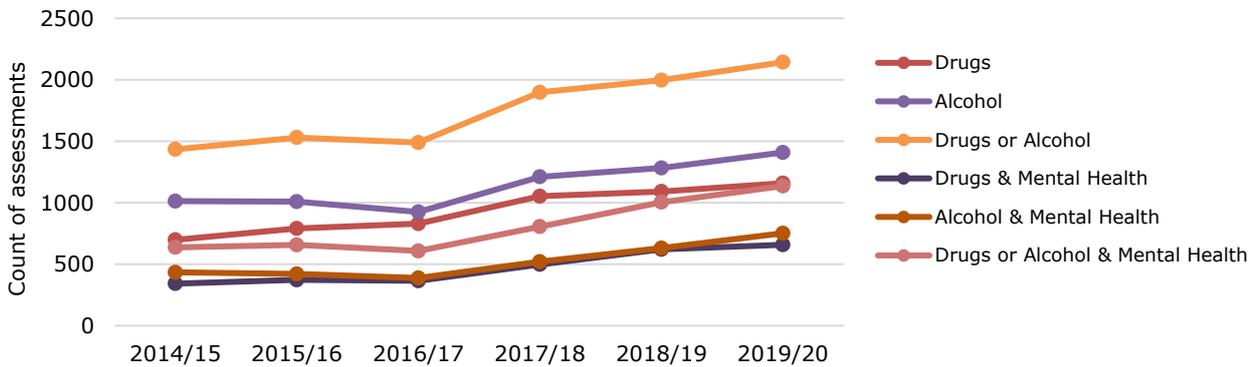
Source: PHE, West Sussex Adults - drugs commissioning support pack 2021-22: key data

4.3.3 Children’s Social Care services

Using internal social care records, we can identify the number and percentage of families where adult substance misuse is referenced in the children’s social care assessment. Adding to this is the added risk from co-existing mental health concerns which can exacerbate risk to children and increase demand on social care systems.

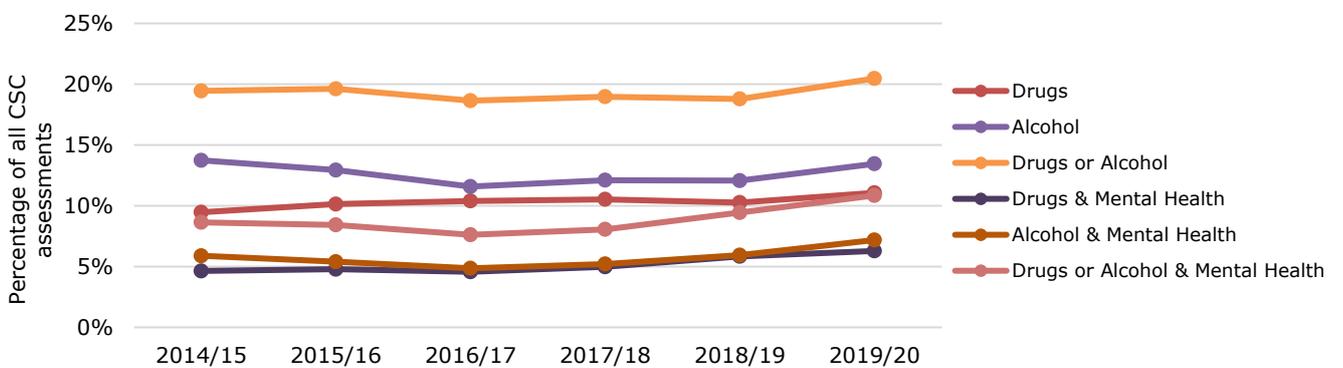
In West Sussex, Children Social Care assessments have increased from roughly 7,400 in 2014/15 to roughly 10,500 in 2019/20. Of these, roughly 2,150 assessments (20%) made reference to adult substance misuse (either drugs or alcohol). Over 1,100 of these also made reference to co-occurring adult mental health problems (11% of all CSC assessments).

Figure 4.2a, Children Social Care assessments with reference to adult substance misuse



Source: West Sussex Children Social Care Performance

Figure 4.2b, Children Social Care assessments with reference to adult substance misuse



Source: West Sussex Children Social Care Performance

4.4 Young people and substance misuse

As with adults, young people rarely develop problems with alcohol or drugs in isolation. Many young people being supported by specialist treatment services also have other problems or vulnerabilities that are linked to their substance misuse.³⁴

These include:

- Mental health issues;
- Experience of domestic violence or sexual exploitation;
- Not being in Education, Employment or Training (NEET);
- Being exposed to parental substance misuse;
- Being in care or a care leaver

For some young people these wider issues may be the cause of their substance misuse problems, and for others, a consequence. Public Health England assert that: *"These young people are already at a significant disadvantage in life and, without effective joined up support, there is a very real risk that their lives get derailed, that drug [and alcohol] misuse continues into adulthood and negatively impacts future generations"*.

Prevention is key, and the most effective approaches focus on strengthening protective factors and reducing risk factors amongst children and young people, as well as building adult capabilities to improve child health outcomes.

4.4.1 National Trends

Alcohol remains the substance most commonly used by young people, although this is a declining trend locally and nationally; however, cannabis is the substance that young people most frequently present to treatment for, followed by alcohol.

National data shows that between 2003 and 2014 there was a decline in the proportion of young people who had ever had an alcoholic drink. In 2018, 44% (confidence interval 41-46%) of young people said they had ever had an alcoholic drink, the same as in 2016. Drug use among young people, appears to be on the increase nationally³⁵. This is a reversal of the declining trend seen since 2001³⁶. Drug use by young people still remains lower than alcohol use.

³⁴ PHE, Public Health Matters, [What we know about young people in alcohol and drug treatment](#) (2017)

³⁵ NHS Digital, [Smoking, Drinking and Drug Use among Young People in England: 2018](#) (2019)

³⁶ HSCIC, [Smoking, drinking and drug use among young people in England: 2014](#) (2014)

4.4.2 Local Prevalence Data

The *What About YOUTH* (WAY) survey 2014 was a one-off survey designed to collect robust local authority level data on a range of health behaviours amongst 15 year-olds, including whether they smoke, drink alcohol or have taken drugs³⁷. Table 4.8 below shows some of the findings for West Sussex.

Table 4.8. Alcohol and Cannabis use amongst 15-year-olds

Self-reported use	West Sussex	England
Regular drinkers (drinking at least once a week)	7.7%	6.2%
Drunk in the last 4 weeks	19.7%	14.6%
Ever had an alcoholic drink	69.0%	62.4%
Ever tried cannabis	13.6%	10.7%
Used cannabis in the last month	6.2%	4.6%
Used drugs (excluding cannabis) in the last month	1.3%	0.9%

Source: What About YOUTH (WAY) Survey (2014)

These data tell us that, compared to the England average, young people in West Sussex are more likely to binge drink, and that they are both more likely to have ever used cannabis and to have used it recently.

Relevant findings from 'Lifestyles of 14 to 15 year-olds in West Sussex: 2015' report³⁸ include:

- 3.7% of 14-15 year-olds surveyed regularly drink alcohol.
- 36.3% of 14-15 year-olds surveyed occasionally drink alcohol.
- Of the 40% of 14-15 year-olds who drink occasionally or regularly, 89% drink once a week or less, 9% drink 2-3 times per week, 2% drink on 4 or more days per week.
- Beer is most commonly consumed by boys and spirits most commonly consumed by girls.
- Of the 40% of 14-15 year-olds who drink occasionally or regularly, 43.9% occasionally drink with the intention of getting drunk, and 11.6% regularly drink with the intention of getting drunk.
- The proportion of young people who drink alcohol in their own homes has increased in recent years from 47% in 2009 to 61% in 2014.

The West Sussex 'Local Alcohol Profile' shows that Under 18's admissions for alcohol-specific conditions have been on a downward trend since 2007, but this decrease has levelled off in recent years, following an increase in admissions for Under 18 year old males. Admissions for males and females remain similar to the England average. The current West Sussex rate of hospital

³⁷ West Sussex County Council, PHSRU, [West Sussex Child Health Profile](#) (2018)

³⁸ West Sussex County Council, PHSRU, [Lifestyles of 14 to 15 year-olds in West Sussex](#) (2015)

admission episodes for alcohol-specific conditions in under 18s (male and female) is 34.6 per 100,000 population. This is statistically similar to the England average of 31.6³⁹.

Public Health England release data from 'Problem parental drug and alcohol use: a toolkit for local authorities'.⁴⁰ In West Sussex:

- 1,494 adults with an alcohol dependency live with children,
- 2,710 children live with an adult with alcohol dependency,
- 667 adults with an opiate dependency live with children,
- 1,180 children live with an adult with opiate dependency,
- Alcohol is a risk factor in 21.8% of West Sussex Children In Need assessments, compared to 18.7% regional and 18.0% England average,
- Drugs are a risk factor in 22.5% of West Sussex Children In Need assessments, compared to 19.4% regional and 19.4% England average.

4.5 Substance misuse amongst sex workers

There is a significant and complex relationship between drug use and sex work, particularly for cocaine, heroin and non-prescription methadone.⁴¹ Sex work is one of three main indicators which have been identified that can 'trap' young people in problematic drug use (the more indicators an individual is exposed to the greater the risk):

1. Working in outdoor and independent drifter sex worker sectors (in comparison to 'indoor associated' or 'independent entrepreneurial');
2. Experience of hard drugs or sex work under the age of 18;
3. Experiencing one or more vulnerability factors: convictions, homelessness or having been 'looked after' by local authority (those who had been 'looked after' reported having started both sex work and drug use at a younger age).

Not having problematic drug use as a principal motivation for sex work is one of the most important factors for leaving sex work and ceasing problematic drug use is seen as the 'key to freedom' from being trapped in multiple vulnerabilities. Residential based treatments have an additional benefit of removing individuals from their vulnerable environment. Non-governmental organisations (NGOs) have noted the involvement of abusive partners and part of this abuse was the expectation of payment for their mutual drug/alcohol misuse via selling sex.⁴² Substance

³⁹ PHE, Fingertips (2020)

⁴⁰ PHE, [Problem parental drug and alcohol use: a toolkit for local authorities](#) (2018)

⁴¹ UK Home Office, [Vulnerability and involvement in drug use and sex work](#) (2003)

⁴² Centre for Gender and Violence Research, University of Bristol, [The nature and prevalence of prostitution and sex work in England and Wales today](#) (2019)

misuse was also identified as increasing risk of harm, for example consumption of alcohol in strip-clubs increasing potential for assault, and for male sex workers 'chemsex' was a particular risk.

Limited national strategy exists for provision of support services to vulnerable women.⁴³ These women are at high risk of having mental health problems and poor physical health as well as being at risk of violence and assault. They often have other existing vulnerabilities including previous sexual abuse, low educational attainment, increased relative poverty, leaving home at a young age and homelessness. The risks they face as a result of substance use and prostitution include assault, arrest and incarceration. Additionally, they face sexual health risks such as sexually transmitted infections and HIV transmission, the HIV risk is increased if they also inject drugs.

Women involved in street-based sex work and substance misuse often feel a 'double stigma' which can impact on their mental health and self-esteem. The stigma associated can often mean they are hidden and so gaining reliable estimates of the number of women affected is difficult. Specific barriers include accessing services in business opening hours, lack of childcare provision, difficulty in key-worker relationship including lack of consistency, stigmatising attitudes and their age and gender. Further barriers include a lack of support relating to housing, employment and ongoing support. Furthermore, sex workers can often have children or become pregnant, or for some women children can be a motivating factor; however, for others fear of children being taken away can lead to avoiding services and if children are removed then can remove all motivation to engage with services.

National recommendations for improved services include:

- Accessibility, with evening and weekend opening, mobile outreach, childcare arrangements and some drop in or open access support.
- Non-judgemental services, through training of all staff to be sensitive, supportive and non-judgemental, as these women can often have low self-esteem due to stigma.
- Women-only provision, ideally services would be women specific or have separate groups or spaces for women as many women will have experienced violence or assault and so may feel more comfortable in women only settings.
- Access to other relevant support either in house or close links to other services; domestic and sexual violence support, sexual health, housing and employment and a provision of ongoing aftercare. A number of these sex-workers do not have a strong support network and so ensuring provision of the correct support will improve their likelihood of successfully turning their lives around.

⁴³ DrugScope and AVA, [The Challenge of Change: Improving services for women involved in prostitution and substance use](#) (2016)

4.6 Exploitation through county lines and modern slavery

4.6.1 County Lines

'County lines' is a term that refers to drugs being transported from one area to another, often across police and local authority boundaries, typically moving drugs from large cities and urban areas to sell in rural or suburban communities. The transporting of drugs is usually carried out by children or vulnerable people who have been coerced by gangs. The 'county line' is the dedicated mobile phone line by which the drugs are ordered. This trend results in the communities in which the drugs are taken experiencing increased levels of exploitation, violence and weapons-related crime.

In addition to exploiting young and vulnerable people to act as drug runners or to move cash, some dealers take over the property of a vulnerable person and conduct their business from their home, known as 'cuckooing'. These exploited persons will often experience physical, mental and sexual abuse.⁴⁴

County lines cause harm in local communities. Problems include knife crime and links to modern slavery and human trafficking.⁴⁵ Multiagency working is important in tackling county lines, including police working with the national crime agency, and local partners. For example, children are at risk of exploitation when in and outside of school and support is required beyond the age of eighteen. Those involved with county lines, particularly children and vulnerable adults can be considered both as victims and offenders and a balance is needed between safeguarding victims, disrupting criminal operations and prosecuting offenders.

Crack cocaine and heroin remain the most commonly supplied drugs. Some movement of powder cocaine and cannabis exist but are thought to be supplementary to the movement of other drugs.⁴⁶ Roughly 40% of movement is carried out by train and so joint working with the British Transport Police is required. The national county lines coordination centre have identified eight main areas of harm:

- Linked to Child Sexual Exploitation and Abuse;
- Access to firearms;
- Trafficking;
- Local juveniles trafficked or criminally exploited;
- Out of force juveniles trafficked or criminally exploited;
- Vulnerable adults trafficked or criminally exploited;
- Cuckooed addresses;
- Serious physical violence evidenced.

⁴⁴ Source: National Crime Agency, [County Lines](#) (2020)

⁴⁵ Source: HMICFRS, [Both sides of the coin: An inspection of how the police and National Crime Agency consider vulnerable people who are both victims and offenders in 'county lines' drug offending](#) (2020)

⁴⁶ Source: National Crime Agency, [County Lines](#) (2020)

Sussex police report they see children supplying drugs who have been exploited by criminal gangs, these children include those who have travelled from London to Sussex and Sussex children exploited and targeted by London gangs to deal locally. At the end of 2019, Sussex Police created a Tactical Enforcement Unit, with a purpose of capturing some of the most wanted offenders including those involved in county lines drug gangs.⁴⁷ In January 2020, there were approximately 65 active county lines (networks), using more than 350 'deal lines' (individual phone lines). These numbers vary, with police disrupting lines but new lines are continually established. The Sussex Police and Crime commissioner highlights that the violence, drug dealing, and exploitation associated with county lines activity often have a particular impact on young people and vulnerable adults.⁴⁸ 'County lines' was one of the biggest threats facing the area and the seventh highest award from the England and Wales Early Intervention Youth Fund was allocated to Sussex Police to initiate 'REBOOT' an early intervention youth programme.⁴⁹

4.6.2 Modern slavery

Modern slavery is defined by Sussex Police as the illegal exploitation of people for personal or commercial gain, including sexual exploitation, domestic servitude, forced labour criminal exploitation and organ harvesting. Victims can be any gender, any ethnicity or age and may not be aware they are a victim of modern slavery.⁵⁰ Modern slavery is often associated with county lines and drug trafficking. Modern slavery can impact considerably on the individual's physical and mental health, varying depending on the context.⁵¹

Vulnerable groups include those with alcohol misuse problems, with mental health problems or have learning disabilities and homeless individuals. Victims can be paid in alcohol or drugs and offenders coerce victims by controlling supply of the substances to which they are addicted. People with an alcohol addiction can be more vulnerable to becoming a victim in modern slavery and modern slavery victims may turn to alcohol as a way of dealing with what they have suffered. Strategic partnerships can be beneficial, with modern slavery subcontractors being brought together with commissioners and data and intelligence sharing between all involved in local strategic partnerships.⁵²

In the UK, 'first responder' organisations refer potential victims of modern slavery to the National Referral Mechanism (NRM) and adults with capacity must consent to the referral. In 2019, 10,627 NRM referrals of potential victims were made (a 52% increase from 2018). The majority claimed

⁴⁷ Source: Sussex Police Press Release, [Tactical Enforcement Unit Expands into the West](#) (2020)

⁴⁸ Source: Spirit FM, [Police keep up pressure on 'county lines' drug dealers](#) (2019)

⁴⁹ Source: Sussex Police, [Police and Crime Commissioner Annual Report](#) (2019)

⁵⁰ Source: Sussex Police, [Modern Slavery](#) (2019)

⁵¹ Source: PHE, [Modern Slavery and Public Health](#) (2017)

⁵² Source: The Salvation Army & Black Country Women's Aid, [A few doors down - The links between substance misuse and modern slavery](#) (2019)

they were exploited in the UK; 43% of referrals were for potential victims exploited as minors. 'Criminal exploitation' is the most common form of modern slavery among minors, and the drive behind this is an increase in the identification of county lines cases. UK nationals account for 27% of all potential victims, followed by Albanian and then Vietnamese. In 2019 Sussex Police received 380 referrals to investigate (compared to 165 in the previous year).⁵³

Modern slavery was highlighted as one of the countywide priorities in Sussex (alongside county lines and serious organised crimes). A dedicated modern slavery delivery manager position has been created which has contributed to increased reporting, and delivery of training to police teams and local authorities, business, academic establishments and faith dioceses, as well as working with local, regional and national partners. During the past several years, over a third of known Sussex-wide modern slavery-related crime occurred in Crawley.

Table 4.9, Sussex police recorded modern slavery crime⁵⁴

Period	Pan-Sussex	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
16/17	35	22	0	1	2	16	1	1	1
17/18	78	34	0	2	2	25	2	1	2
18/19	159	91	0	14	5	50	2	6	14
19/20	316	153	2	12	5	122	1	5	6

Note, Geographies may not sum to totals, as some incidences are not assigned to local areas

Source: Home Office, Police recorded crime and outcomes open data tables

Table 4.10, Police recorded trafficking in controlled drug crime⁵⁵

Period	Pan-Sussex	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
16/17	575	176	10	35	20	54	22	12	23
17/18	536	187	14	39	18	46	9	19	42
18/19	576	230	10	33	20	92	22	15	38
19/20	580	252	16	38	30	71	19	41	37

Note, Geographies may not sum to totals, as some incidences are not assigned to local areas

Source: Home Office, Police recorded crime and outcomes open data tables

4.7 Homelessness and housing issues

In 2016/17, a local homelessness needs assessment was conducted by West Sussex Public Health, in collaboration with Homeless Link, Worthing Churches Homelessness Project, Adur & Worthing Council and a number of charitable organisations.⁵⁶ As part of the collaborative approach, they used The Homeless Health Audit Tool, created by Homeless link to collect data from the participants, during the Winter of 2016, to coincide with the statutory provision of night shelters to ensure that as many participants as possible were recruited. This work focused on the needs of single homeless people only – a number of whom do not meet the 'priority need' criteria.⁵⁷ The

⁵³ Source: UK Home Office, [National Referral Mechanism statistics UK: End of year summary](#) (2020)

⁵⁴ Source: Home Office, [Police recorded crime and outcomes open data tables](#) (2020)

⁵⁵ Source: Home Office, [Police recorded crime and outcomes open data tables](#) (2020)

⁵⁶ Source: West Sussex PHSRU, [West Sussex Homelessness Needs Audit](#) (2016)

⁵⁷ The total homeless population in West Sussex also includes families and other people in priority need.

participants in this audit were accessing services for health, or homeless related support. However, not all single homeless people will engage with services, and therefore the participants are an atypical sample of the local single homeless population.

When asked about alcohol use, 108 participants (49%) stated they drank at least once a week.⁵⁸ Of these, 55 reported drinking five or more times a week with 17% reporting that they had not had any alcoholic drink within the past year. This number increased to 51% for those who reported drinking one or two drinks a month or less. Alcohol abstinence was more common among women completing the survey, with 28% of females reported not drinking in the past year, compared with 14% of males who reported they were abstinent.

Of those who regularly drank, 51% reported drinking in excess of 10 units.⁵⁹ When compared to the national estimates from Homeless Link, the proportion of those drinking in excess of 10 units is higher in West Sussex. Self-reported alcohol misuse was identified in 38 participants (17%), while an additional 38 were currently in recovery from alcohol misuse issues.

Table 4.11 Number of units respondents thought they drank during a typical drinking session

Units of alcohol	West Sussex	Homeless Link (National estimate)
1-2 units per day	14%	16%
3-4 units per day	17%	22%
5-6 units per day	13%	16%
7-9 units per day	5%	11%
10+ units per day	51%	35%

Source: West Sussex PHSRU, Homelessness Needs Assessment (2016)

Of the 137 respondents that reported not to have an alcohol problem, 21 said they drank at least 3 days a week. Of those reporting current alcohol misuse, only half were receiving support or treatment, with twelve respondents reporting that they needed further help. A total of 19 were not receiving any support or treatment, with 14 of those reporting that they would benefit from it.

Of the 38 in recovery, 25 (66%) were currently in receipt of support or treatment. Of these, 18 (72%) think that the service met their needs, while the remaining seven thought they needed more help. Advice and information (e.g. from GPs, A&E departments), self-help groups (Alcoholics Anonymous), peer support, and residential rehabilitation were all widely reported as meeting these needs.

All respondents in recovery who wanted treatment and support were currently receiving it at the time of the audit. There was a positive response to questions about counselling or psychological

⁵⁸ It is commonly asserted that population surveys can provide underestimates of alcohol use, as people believe they drink less than they actually do. i.e. ONS, [Adult drinking habits in Great Britain: 2017](#)

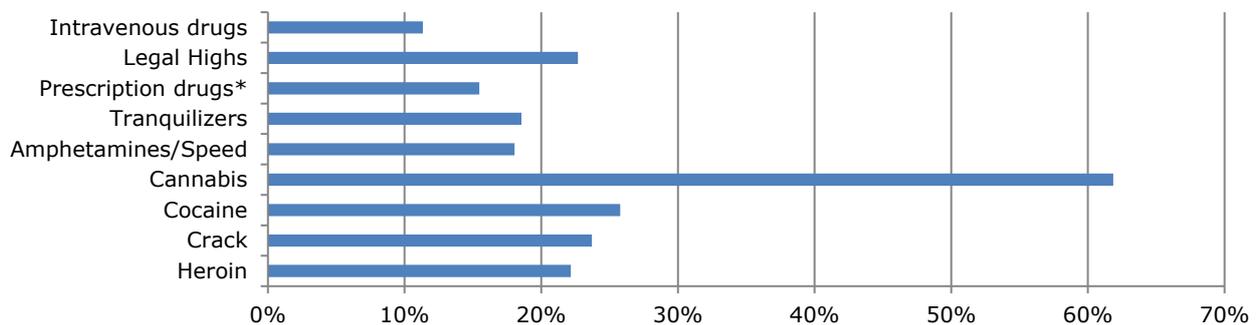
⁵⁹ This is approximately three large glasses of wine or three and a half pints of lager.

treatment: with seven of eight respondents saying it met their needs. Aftercare, peer support, residential rehabilitation, and advice and information also ranked highly: within each category over 70% of respondents stating that the service met their need. Self-help groups such as Alcoholics Anonymous were rated least effective with six of the 21 respondents using those services stating they would still like more help.

When asked what could be improved, tackling alcohol addiction and associated health issues were mentioned by six participants.

Of the 206 responses to the question about recreational drug use, 130 (63%) individuals reported that they had used recreational drugs in the past 12 months.

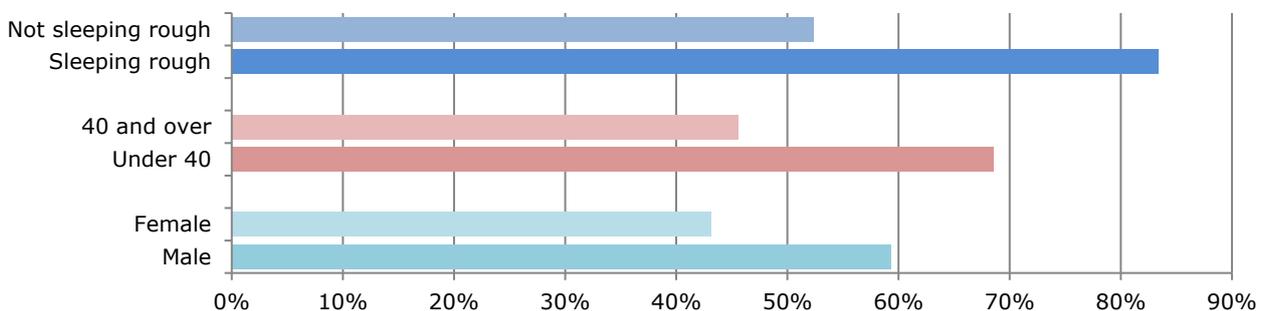
Figure 4.3, Percentage of respondents that have taken drugs within the last 12 months



*Prescription drugs not prescribed to the respondent
 Source: West Sussex PHSRU, Homelessness Needs Assessment (2016)

There were large differences in drug use across different demographics with men more likely to use drugs than women. Those under the age of 40 were also more likely to report drug use than their older counterparts. The biggest difference in reported drug use was seen between those sleeping rough and those not (83% versus 52% respectively).

Figure 4.4 Percentage of respondents that had used any recreational drug in the last 12 months, by demographic



Source: West Sussex PHSRU, Homelessness Needs Assessment (2016)

In terms of individual services or treatment, eight of the ten that were currently in or had previously used residential rehabilitation services, thought the service met their needs. Self-help groups (e.g. Narcotics Anonymous) were not thought to be effective at meeting respondent's

need, with six of the 13 that used the support service needing more help. Advice and information (From GPs, A&E) and community prescribing were also perceived to be of limited benefit.

When asked to provide the reasons behind how and why they last became homeless, 27 (12%) of those who answered, reported that drug and alcohol problems were the primary cause. A further 23 (10%) reported it as their secondary cause.

All respondents were asked whether they use or have used drugs or alcohol as a form of self-medication to cope with their mental health condition. Of the 198 with a listed mental health condition, 186 responded. Over half (n=98) said they self-medicate or have self-medicated in the past.

4.8 Learning disabilities

Public Health England have conducted a review of literature into the increased risk for those with learning disabilities and found that studies are likely to underestimate the problem, as some used self-report measures and others only included people known to learning disability services.⁶⁰

As increasing numbers of people with learning disabilities are living more independently in local communities they're more likely to have access to alcohol and other drugs and, therefore, there's a need for appropriate services to support those who misuse substances.

It's important to note that little is known about the health of the 'hidden majority' of adults with learning disabilities who don't use learning disability services. It is this group of people with more mild learning disabilities who are most likely to misuse alcohol or drugs (PHE, 2016).

Overall, the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population. However, PHE identified increased risk in those who: have borderline to mild learning disabilities; are young and male; or have mental health problems. Interviews with people with learning disabilities who were misusing alcohol or drugs showed that the main reasons for this could be described as 'self-medicating against life's negative experiences'. These included reasons related to psychological trauma, such as bereavement or abuse, or social distance from their community such as isolation and loneliness.

They list other risk factors for substance misuse as including:

- living independently
- boredom or lack of meaningful occupation
- desire to be socially included/loneliness
- limited social skills or low self-esteem
- lack of family contact

⁶⁰ PHE, [Substance misuse and people with learning disabilities: making reasonable adjustments to services](#) (2016)

- impulsivity
- negative life events, for example, neglect, abuse and bereavement
- unemployment or poverty

The review cites a lack of studies into barriers to service provision but maintains that attention should be drawn here to ensure inclusivity and awareness of potential issues. They refer to several guidelines from NICE, which point to best practice and how pathways can support those who experience barriers relating to learning difficulties.

Prevalence in The Community and Higher Risk Groups, Key Summary:

From 2018 estimates, there are between 5,500-9,500 residents in West Sussex in need of treatment for alcohol dependence (point estimate of roughly 7,000). Other research estimates that about a quarter of West Sussex adults (165,000 people) drink above the recommended low-risk levels.

From 2018 estimates, there are between 1,200-3,200 residents using opiates and/or crack cocaine in West Sussex. As it can be difficult for authorities and providers to identify or reach out to residents with substance misuse problems in the community, it is necessary to focus on areas with proxy-indicators for drug use (i.e. economic inequalities) to increase the chances of engaging with these residents.

Around 3,500 pieces of drugs litter have been identified in West Sussex from 2016-2020, and whilst data are incomplete, approximately half of these are needles, barrels or syringes. Nitrous Oxide gas canisters have been a recent priority in Worthing and Adur and findings there account for 89% of all recorded items county-wide.

We also can target specific risk groups to tackle problems for example, heavy alcohol use during pregnancy can lead to foetal alcohol spectrum disorder, a term that encompasses a range of alcohol-related birth defects; affecting up to 3% of all children.

PHE estimate that there are 2,700 children in West Sussex living with an adult with alcohol dependency, though only 375 children are known to live with an adult who entered alcohol treatment in 2019/20. Roughly half of alcohol service admissions are parents or live with children and 14% of these service users are also known to children's services.

Over half of new drug service admissions are parents or live with children and 23% of these are also known to children's services.

In West Sussex, children's services assessments have increased from roughly 7,400-10,500 from 2014-19. Of these, roughly 2,150 assessments (20%) made reference to adult substance misuse (either drugs or alcohol). Over 1,100 of these also made reference to co-occurring adult mental health problems (11% of all children's services assessments).

Risk factors for young people engaging with substance misuse include mental health issues; experience of domestic violence and sexual exploitation; not being in Education, Employment or Training; being exposed to parental substance misuse; being in care or a care leaver.

A range of recommendations exist to support those engaged in sex work, which can lead to mental and physical health problems. Not having problematic drug use as a principal motivation for sex work is one of the most important factors for leaving sex work. Ceasing problematic drug use is seen as the 'key to freedom' from being trapped in multiple vulnerabilities.

In 2019/20 Sussex police recorded 250 incidences of trafficking controlled drugs and 150 incidences of modern slavery crime in West Sussex. Multiagency working is important in tackling county lines. Those involved with county lines, particularly children and vulnerable adults can be considered both as victims and offenders and a balance is needed between safeguarding victims, disrupting criminal operations and prosecuting offenders.

Those with housing or homelessness problems are at a greater risk of the harms of substance misuse and this is especially so for roughly sleepers (4 in 5 of which had taken drugs recreationally in the past year, locally in 2016). At the same time, substance misuse can be a factor leading to housing problems and homelessness.

Efforts should be made to understand the guidelines and advise for identifying and supporting those with learning difficulties who might be suffering from substance misuse issues, as current provision may not always be accessible or appropriate. Those with less visible difficulties are more likely to go unnoticed, which can reduce the success of community support.

5. Community Level Impacts of Substance Misuse

This section covers the main health-related outcomes related to substance misuse and how those from vulnerable groups identified in previous sections may be more affected in these outcomes.

Key headings:

- 5.1 Mental health conditions
- 5.2 Smoking and Chronic Obstructive Pulmonary Disease
- 5.3 Sexual health
- 5.4 Blood-borne viruses (BBV)
- 5.5 Alcohol related hospital admissions
- 5.6 Deaths related to drug and alcohol use
- 5.7 Alcohol and drug-related crime

5.1 Mental health conditions

The occurrence of mental health conditions among people with substance misuse problems is very common. The relationship between substance misuse and mental health conditions is complex. The issues that arise due to the co-occurrence of mental health conditions and substance use include that acute or chronic effects of substance misuse can mimic symptoms of mental health conditions, mental health conditions can impact on a person's substance for example facilitating commencing substance use or risky patterns of substance taking and can also result in increasing substance taking additionally, there are a number of specific associations between mental health disorders and substance use disorders.

There are several possible pathways to explain the co-morbidity between substance misuse disorders and mental health conditions and these include:

- A substance use disorder and mental health condition can exist as independent conditions and their occurrence either due to chance or to a person having the same underlying risk factors.
- Mental health conditions can be a risk factor for substance misuse, this can be via the 'self-medication hypothesis' whereby an individual uses a substance to deal with symptoms arising from the mental health condition. The outcome of this can vary and for some people a substance use disorder may continue independently even after a mental health condition is addressed.
- Substance use can trigger development of an underlying mental health condition for example cannabis use and psychosis.

- A temporary mental health condition can result from substance use during intoxication or withdrawal from a specific substance.⁶¹

There are many potential barriers to accessing treatment services, particularly where individuals have complex co-morbidities, which means that true demand in the community may exceed what is seen via service presentations.⁶²

Of new presentations to alcohol treatment in 2019/20, 365 (54% - 47% of males and 63% of females) were identified as having a mental health need. This is lower than the national average (55% of males and 66% of females) but has increased since the previous year. Of these, 24% of males and 27% of females were recorded as already engaged with the Community Mental Health Team or other mental health services (15% and 17% nationally); 53% of males and 56% of females were receiving mental health treatment from their GP (59% and 64% nationally). In all, 22% of males and 16% of females were not receiving treatment for their assessed mental health problems, which was roughly in line with national averages.

Of the adults who entered drug treatment in 2019/20, 540 (60% - 55% of males and 70% of females) were assessed as having a mental health treatment need (increasing from 53% the previous year). This was higher for non-opiate presentations compared to opiate presentations (68% to 53%). Of these individuals, 72% (68% of males and 79% of females) were already accessing mental health support services; 20% of males and 35% of females were already engaged with the Community Mental Health Team or other mental health services (17% and 21% nationally); and 48% of males and 43% of females were receiving mental health treatment from their GP (48% and 52% nationally). In all, 32% of males and 21% of females were not in receipt of treatment for their assessed mental health problems.

Table 5.1, Adults who entered drug treatment in 2019/20 and were identified as having a mental health treatment need

Treatment cohort	Number of new presentations	Proportion of all presentations	Proportion of male presentations	Proportion of female presentations
Opiates	171	53%	47%	65%
Non-opiates	158	68%	63%	78%
Non-opiates and alcohol	211	61%	57%	69%
All new drug presentations	540	60%	55%	70%

Source: PHE, West Sussex Adults - drugs commissioning support pack 2021-22: key data

⁶¹ Source: EMCDDA, [Perspectives on drugs: Comorbidity of substance use and mental health disorders in Europe](#) (2016)

⁶² Source: West Sussex PHSRU, [West Sussex Drug Related Deaths 2015-17](#) (2019)

5.2 Smoking and Chronic Obstructive Pulmonary Disease

People who use drugs and alcohol are more likely than the general population to also smoke cigarettes. NDTMS data from 2018/19 reveal that smoking prevalence for people entering drug and alcohol service treatment was considerably higher than the general population. Smoking is the biggest cause of preventable deaths in the UK,⁶³ it is a risk factor for many serious health conditions including cardiovascular disease, (for example heart attack and stroke), many and a number of lung problems (for example Chronic Obstructive Pulmonary Disorder (COPD), pneumonia and can worsen asthma and respiratory tract infections).⁶⁴

Alcohol is a risk factor for a number of these conditions and so those who smoke and drink alcohol are at an increased risk. For certain cancers, including throat cancer, the risk among people who both smoke and drink alcohol is greater than a combination of the two risk factors individually.⁶⁵ COPD is a group of conditions, including chronic bronchitis and emphysema, that arise following damage and inflammation of the airways. Symptoms include shortness of breath and a chronic cough, there is no cure and symptoms progress over time. Tobacco smoking is the predominant cause of COPD; however, smoking illicit drugs can also damage the airway, heroin inhalation has been shown to result in severe and early onset emphysema. Furthermore, opioid use can mask the common symptoms of COPD and so can delay a diagnosis.⁶⁶ A retrospective US cohort study found that patients previously treated for substance dependence had an increased cumulative mortality and this was more likely to be from tobacco related than alcohol related underlying cause.⁶⁷

There are a number of reasons why people with substance use disorders are more likely than the general population to smoke, these include that they act on the same reward pathway and so reciprocal enjoyment is enhanced, smoking often counteracts some of the effects of substances, for example the sedative effect of alcohol and can act as an anxiolytic (reducing anxiety) for people with co-morbid stress or psychiatric conditions.⁶⁸ However, despite commonly held beliefs nicotine actually increases stress level and the calming sensation is a result of relieving the nicotine withdrawal and quitting smoking is often found to improve treatment outcomes.

Several studies and reviews have found that offering smoking cessation, to users engaged with substance misuse services is effective and significantly associated with tobacco abstinence and does not adversely impact substance treatment outcome and some studies even suggested that

⁶³ Source: NHS Smoke Free, [How smoking affects your body](#) (2020)

⁶⁴ Source: NHS, [What are the health risks of smoking?](#) (2020)

⁶⁵ Source: Pelucchi et al., [Cancer risk associated with alcohol and tobacco use: focus on upper aero-digestive tract and liver](#) (2006)

⁶⁶ Source: King's Health Partners, [Respiratory: Improving lung health in addictions services](#) (2020)

⁶⁷ Source: Hurt et al., [Mortality Following Inpatient Addictions Treatment. Role of Tobacco Use in a Community-Based Cohort](#) (1996)

⁶⁸ Source: Mendelsohn & Wodak, [Smoking cessation in people with alcohol and other drug problems](#) (2016)

treatment outcomes were improved.^{69,70,71} One review suggested that for service users who are not yet dependent on tobacco a preventative approach may be required to prevent future tobacco dependence.⁷² Nationally and locally the proportion of service users who smoke tobacco who were provided with smoking cessation interventions has been very low.

5.2.1 Alcohol treatment

Of the 425 service users starting alcohol treatment in 2018/19, 194 disclosed smoking tobacco at start of treatment (48% of males and 42% of females), roughly in line with national rates of 44%. At their outcome review, 48 of these (25%) had reported quitting smoking, lower than the national benchmark (31%). Offsetting this tobacco cessation, of the 231 non-smokers at start of treatment, 44 (19%) had taken up smoking by the time of their review; worse than the national benchmark (12%). Only 1% of service users received a targeted smoking cessation intervention (nationally 3%).

5.2.2 All drug treatment

Of the 455 service users starting drug treatment in 2018/19, 358 disclosed smoking tobacco at start of treatment (78% of males and 81% of females), higher than the national rates of 67%. At their outcome review, 62 of these (17%) had reported quitting smoking, lower than the national benchmark (24%). Further, of the 97 non-smokers at start of treatment, 25 (26%) had taken up smoking by the time of their review; better than the national benchmark (32%). Only 1% of service users received a targeted smoking cessation intervention (nationally 3%).

5.2.3 Opiates

Of the 239 service users starting opiate treatment in 2018/19, 197 disclosed smoking tobacco at start of treatment (83% of males and 81% of females), higher than the national rates of 70%. At their outcome review, 20 of these (10%) had reported quitting smoking, lower than the national benchmark (21%). Further, of the 42 non-smokers at start of treatment, 15 (36%) had taken up smoking by the time of their review; better than the national benchmark (41%). No service users received a targeted smoking cessation intervention (nationally 2%).

⁶⁹ Source: Apollonio et al., [Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders](#) (2016)

⁷⁰ Source: SAMHSA-HRSA, [Establishing Smoking Cessation Initiatives in Health Centres](#) (2011)

⁷¹ Source: Thurgood et al., [A Systematic Review of Smoking Cessation Interventions for Adults in Substance Abuse Treatment or Recovery](#) (2016)

⁷² Source: SAMHSA-HRSA, [Establishing Smoking Cessation Initiatives in Health Centres](#) (2011)

5.2.4 Non-opiates only

Of the 79 service users starting treatment for non-opiate drugs in 2018/19, 48 disclosed smoking tobacco at start of treatment (58% of males and 67% of females), roughly in line with national rates of 60%. At their outcome review, 10 of these (21%) had reported quitting smoking, lower than the national benchmark (29%). Offsetting this tobacco cessation, of the 31 non-smokers at start of treatment, 3 (10%) had taken up smoking by the time of their review; worse than the national benchmark (22%). No service users received a targeted smoking cessation intervention (nationally 2%).

5.2.5 Non-opiates and alcohol

Of the 137 service users starting treatment for both alcohol and non-opiates in 2018/19, 113 disclosed smoking tobacco at start of treatment (79% of males and 90% of females), higher than the national rates of 63%. At their outcome review, 32 of these (28%) had reported quitting smoking, in line with the national benchmark (29%). Offsetting this tobacco cessation, of the 24 non-smokers at start of treatment, 7 (29%) had taken up smoking by the time of their review; worse than the national benchmark (24%). Only 2% of service users received a targeted smoking cessation intervention (nationally 4%).

5.3 Sexual health

5.3.1 Reviewing local sexual health and substance misuse needs

In 2019, a comprehensive sexual health and HIV needs assessment was conducted in West Sussex. A feature of this was to examine the increased risk factors to those who misuse substances and the findings of this assessment are included here.⁷³ In young people, use of drugs and alcohol was associated with riskier sexual behaviour. Young people with substance problems are more likely to engage in risky sexual behaviours during adolescence and to continue risky sexual behaviours to the extent that substance problems persist. Risk reduction education is a crucial component of substance abuse treatment for young people.

In West Sussex, drug and alcohol treatment services are split into services for people under 25 years and for people over 25. The U25 service is registered for C-card condom distribution and chlamydia testing scheme.

⁷³ Source: WSCC PHSRU, [Integrated Sexual Health & HIV Needs Assessment](#) (2019)

A number of issues were raised in relation to substance misuse and sexual health (and between services treating substance misuse and sexual health services):

- There was no set pathway between services. Access and use tends to be on an *ad hoc* basis and dependent on the person working with the client and the relationship built up between services. There were some very good relationships but also concern that these could be subject to change as circumstances or staff change.
- Local variations in terms of pathways and contacts were found. There was some direct contact, meaning sometimes young people would be booked into sexual health services with an appointment to avoid waiting in the clinic; usually under-18s only.
- For older people accessing the service, sexual health needs tended to be revealed at the assessment stage. In unpacking problems with substance misuse issues, it might be necessary to refer into sexual health services for the wellbeing of the person.
- Issues of substance misuse mean that some clients face additional risks and concerns, including where someone has turned to sex work or is being sexually exploited (e.g. engaged in sex for additional supply of misused substance). There may also be cases of Child Sexual Exploitation.
- The range of people seen in substance misuse services mean that there are also cases where people accessing the service are sexually inexperienced and have lower sexual health literacy, so the health promotion role is necessary (i.e. training of staff members of the substance misuse service).

In relation to substance misuse services, key informants thought that there was a need to consider how services work together to achieve better results across the health and public health system and there may be a number of opportunities for joint working:

- The substance misuse service can be supported to have HIV testing capability within the service.
- Connections to online services run by the integrated service.
- Greater links and referrals between services, i.e. getting people from substance misuse service into the integrated service and vice versa.
- It was noted that a project working with women who have had one or more children taken into care (the PAUSE project) had developed strong referral pathways and links with integrated service. If there were similar pathways for providing Long Acting Reversible Contraception (LARC) to some people accessing the substance misuse service to support prevention of pregnancies before children are taken into care – e.g. avoid any removals. As such, substance misuse services should be viewed as part of the wider preventative picture and work should be undertaken to get existing systems to work more effectively together.

5.3.2 Recent developments in sexual health provision

Since the 2019 needs assessment, a number of advances have been made in the context of the above findings. Sexual health providers have met with substance misuse providers, CGL and have agreed intentions to improve opportunistic access to sexual health for drug and alcohol clients. This will be tracked and managed by the sexual health commissioner, as part of contract management. These include:

- Reviewing current assessment for both sexual health and substance misuse services and training/support around brief information and advice.
- Overhauling existing condom distribution and chlamydia screening programmes (which have been historically poorly taken up), with a view to developing a more integrated screening pathway alongside commissioned blood borne virus testing.
- Discussions around feasibility of developing Patient Group Directives (PGDs) for emergency & ongoing contraception.⁷⁴
- Substance misuse providers are being included as a key stakeholder on the sexual health strategy group, which should see a focus on reaching more vulnerable parts of populations.
- All frontline sexual health staff will now be trained in the Making Every Contact Count principles. Users will routinely self-screen for risky drinking, using the AUDIT- C tool, as part of face to face attendance. This is as part of a roll-out of a Making Every Contact Count (MECC) approach, as part of MECC roll-out.
- Sexual health providers are routinely screening all users who request online testing for drug and alcohol use. They are reviewing the current online triage to include links to CGL and the West Sussex Wellbeing programme for those flagging concerns regarding substance misuse, to facilitate information and self-referral.

5.4 Blood-borne viruses (BBV)

5.4.1 National reviews into BBV

Public Health England recently updated their review into infections among people who inject drugs.⁷⁵ National findings are summarised here:

Preventable bacterial infections are increasing: Over half of people who inject drugs (PWID) report having a recent symptom of a bacterial infection. Severe bacterial infections in PWID have been increasing since 2013/14. The cause of the rise is likely to include the ageing populations of PWID with poorer vein and skin health, changes in injection practices with recent increases in groin

⁷⁴ [Patient Group Directions](#) (PGDs) are a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

⁷⁵ Source: PHE, [Shooting Up: Infections among people who inject drugs in the UK](#) (2019)

injections, a large proportion of PWID reporting homelessness, and likely conditions of poorer general hygiene and unsterile injecting.

There is early evidence for a reduction in chronic Hepatitis C prevalence (HCV), however rates of new infection are unchanged: Roughly 1 in every 4 PWID are infected with HCV. Early evidence for an increase in testing and uptake of treatment among PWID in line with HCV elimination activities can be observed in 2018. However, there remains much room for improvement. There is no indication of a reduction in the number of new HCV infections over recent years, including amongst individuals who have recently started injecting. Together with continued scale-up of interventions to improve testing and treatment for HCV, ongoing efforts to improve harm reduction such as opioid substitution therapy (OST) and needle and syringe programmes (NSP) will be essential to reach the WHO goals and eliminate HCV by 2030.

HIV levels remain low, but risks continue: In the UK, around 1 in 100 PWID are living with HIV. Most PWID living with HIV have been diagnosed and are accessing HIV care. However, HIV is often diagnosed at a late stage among PWID. It is crucial that HIV testing is offered regularly, and that care pathways for HIV are maintained and adapt to changing patterns of risk.

Hepatitis B vaccine uptake needs to be sustained, particularly in younger age groups: In the UK, around 1 in every 200 PWID is living with hepatitis B infection. About three quarters of PWID report being vaccinated against hepatitis B, but uptake of this preventative intervention has not improved in recent years and is particularly low among younger age groups and in those who have recently begun injecting.

Continued sharing and re-use of injecting equipment remains a concern: Sharing levels have not improved in recent years and only around 3 in 5 PWID reported adequate needle/syringe provision for their needs. Re-use of an individual's own injecting equipment is commonly reported in the UK and can also put individuals at risk of infection.

Changes in psychoactive drug preferences could lead to riskier injecting practices: The changing patterns of psychoactive drug use remain a concern because this can lead to riskier injecting practices, sharing equipment, groin injecting, and frequency. Injection of crack cocaine has increased in England and Wales.

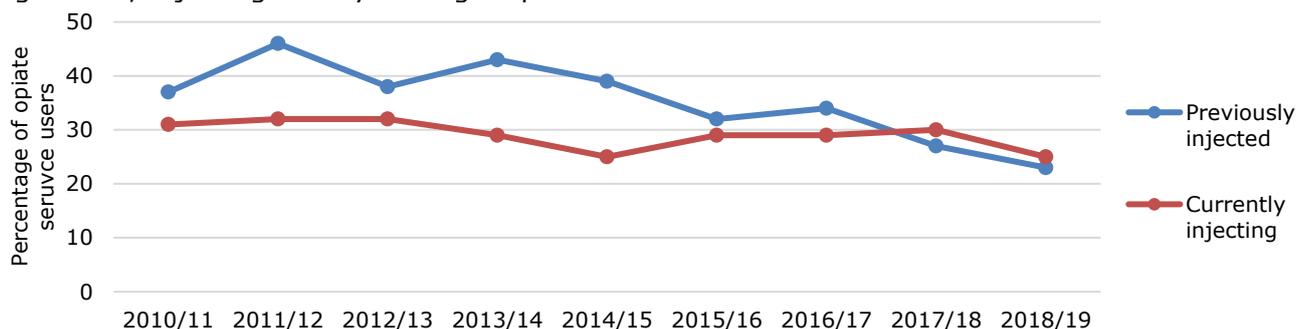
Provision of effective interventions need to be maintained and optimised: These interventions include Needle and Syringe Programmes (NSP), Opioid Substitution Therapy (OST) and other treatments for drug misuse and dependence. Vaccinations and diagnostic tests for infections need to be routinely and regularly offered to people who inject or have previously injected drugs. Care pathways and treatments should be optimised for those testing positive for blood borne viruses.

5.4.2 Hepatitis at the local level

Hepatitis C testing and referral data will vary from area to area depending on local systems and pathways, the availability of test results to providers and where/how hepatitis C treatment is provided.⁷⁶

Of the 172 previous or current injectors new to treatment in 2018/19 and eligible for Hepatitis C test, 90% of males and 95% of females received one, higher than the national benchmark (76%). Of those tested (and excluding 'unknown' or 'not recorded' cases) with a Hepatitis C antibody test, 31% were recorded as positive, and of those with a Hepatitis C PCR test, (measures the amount of Hepatitis C in the bloodstream) 23% were recorded as positive. These are both roughly in line with national benchmarks. Of the 679 adults new to drugs treatment in 2018/19 who were eligible for Hepatitis B vaccination, 54% accepted one, higher than the national benchmark (40%). Of those who accepted a vaccination, 8% started a course of vaccination and a further 11% completed a course of vaccination, in line with national figures. Locally the proportion of those seeking support for opiate use who have injected drugs has been decreasing in recent years.

Figure 5.1, Injecting history amongst opiate service users in West Sussex



Source: NDTMS

5.5 Alcohol related hospital admissions

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

The Government has said that everyone has a role to play in reducing the harmful use of alcohol - this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy (2012). This

⁷⁶ Source: PHE, West Sussex Adults - drugs commissioning support pack 2021-22: key data

ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network. Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm. Reducing alcohol-related harm was one of Public Health England's seven priorities for the five year period 2014-19.⁷⁷ Drug or alcohol use are not mentioned as a priority in PHE's new strategy, however, though they are mentioned as a part of general healthy lifestyles.⁷⁸

5.5.1 Alcohol-related inpatient hospital admissions

Nationally there were an estimated 358,000 incidents in 2018/19 where the primary reason for admission to hospital was attributed to alcohol, 6% higher than the previous year and accounted for 2.1% of all hospital admissions. Of these, 62% were males and 40% overall were between the ages of 45 and 64 years. When the admission criteria were expanded to a 'broad measure', (where the primary reason for hospital admission, or a secondary diagnosis, was linked to alcohol) this increased to 1.3 million admissions, 7.4% of all hospital admissions, 47% aged between 55 and 74 and nearly 2/3rds male.

In the same period in West Sussex there were 583 admissions per 100,000 people, where alcohol was recorded as the primary reason and 1,887 per 100,000 people for the broader measure. These were significantly lower than the national benchmarks of 663 and 2,367 per 100,000 for narrow and broad measures respectively. Amongst under 18s there were 35 admissions per 100,000, which was higher, - but not significantly so, - than national benchmarks of 32 per 100,000.⁷⁹

Health conditions in which alcohol plays a causative role can be classified as either 'alcohol-specific' or 'alcohol-related'. In 2017/18 there were 471 alcohol-specific cases per 100,000 residents (CI: 457-486), where alcohol was causally implicated in all cases, e.g. alcohol poisoning or alcoholic liver disease, lower than the national average of (570 per 100,000). For the period 2015-18, of those aged under 18 years old, there were 32 admissions per 100,000 residents (95% CI: 27-37), in line with the national averages (33 per 100,000).

Alternatively, we can view 'alcohol-related conditions' which include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases, for example high blood pressure, various cancers and falls. In 2017/18, there were 1,796 admissions for alcohol related conditions.

⁷⁷ Source: PHE, [From evidence into action: opportunities to protect and improve the nation's health](#) (2014)

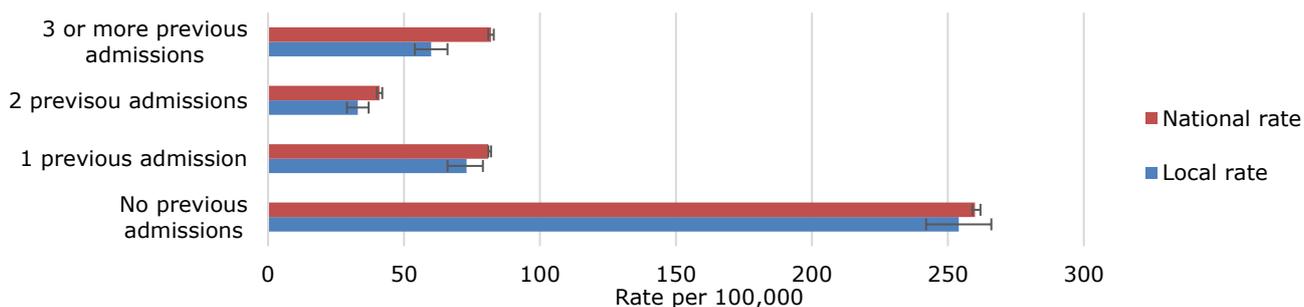
⁷⁸ Source: PHE, [PHE Strategy 2020-2025](#) (2020)

⁷⁹ Source: PHE Fingertips, [Local Alcohol Profiles for England](#) (2020)

5.5.2 Repeated admissions

For the period 2019/20, 60% of adults with alcohol-specific hospital admissions had no previous admissions (56% nationally) and 14% had three or more previous admissions (18% nationally). Figure 5.2 shows the rates per 100,000 people in the community and indicates that West Sussex has a lower rate of repeat admissions than national benchmarks, but roughly 60 residents per 100,000 had at least three previous admissions.

Figure 5.2, Adults with alcohol-specific hospital admissions and number of admissions in the preceding 24 months* (2018/19)

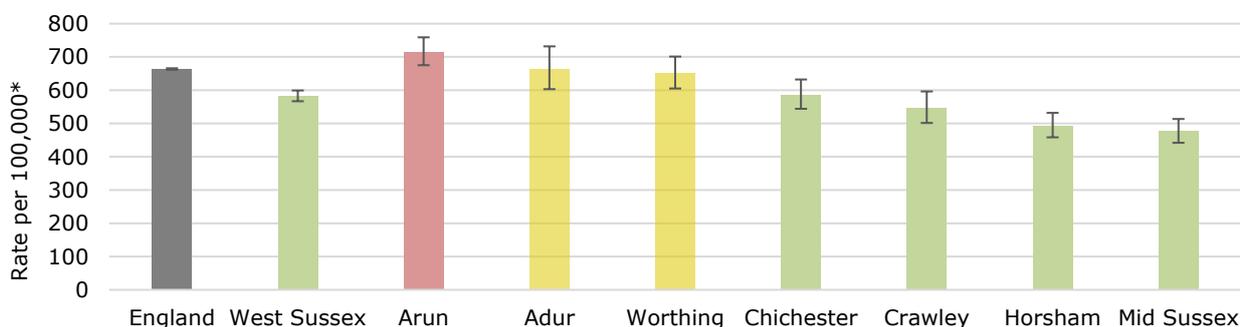


*Hospital Episode Statistics data (NHS Digital – Provisional data (2019/20) and ONS population estimates
Source: PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

5.5.3 Local variations of alcohol related admissions

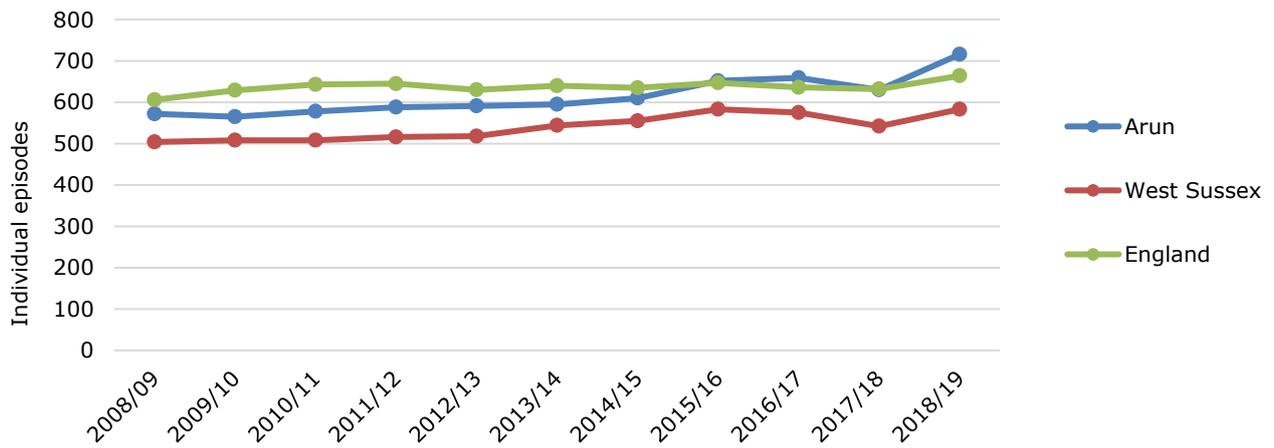
Whilst hospital admissions for alcohol-related conditions have been increasing nationally and locally in the past decade, those in Arun have been outgrowing West Sussex and England averages recently. This is considerably so for Arun males (917 per 100,000, versus a national average of 851 per 100,000). Females in Worthing also surpass national averages with 570 per 100,000 versus 494 per 100,000 respectively and these rates in Worthing (and to a lesser extent Adur) have been significantly higher than national averages for much of the past decade.

Figure 5.3, Admission episodes for alcohol-related conditions, 2018/19



*95% confidence intervals, based on ONS population estimates
Source: PHE Fingertips

Figure 5.4, Admission episodes for alcohol-related conditions over time



Source: PHE Fingertips

Full Public Health England outcomes for alcohol-related admissions are shown below, in Figure 5.5. Breakdowns by sex (not shown) reveal that females, particularly aged under 40 years have been consistently higher than national benchmarks for much of the past decade in coastal areas (Arun, Worthing and Adur).

Figure 5.5, Public Health Outcomes for alcohol related hospital admissions (rates per 100,000*)

Indicator	Period	Eng	W. Sx	Adur	Arun	Chi	Craw	Hor	Mid	Wor
Admission episodes for alcohol-related conditions (Narrow)	18/19	664	583	665	716	587	547	494	477	652
Admission episodes for alcohol-specific conditions - Under 18s	16/17 - 18/19	31.6	34.6	51.7	41.2	45.5	18.6	28.8	35.9	38.5
Admission episodes for alcohol-specific conditions	18/19	626	507	494	694	618	463	351	397	528
Admission episodes for alcohol-related conditions (Broad)	18/19	2367	1887	2075	2187	1838	2162	1661	1546	1986
Quarterly admission episodes for alcohol-related conditions (Narrow)	19/20 Q2	619	559	686	655	541	573	530	447	606
Quarterly admission episodes for alcohol-related conditions (Broad)	19/20 Q2	2244	1811	2042	2154	1808	2010	1604	1474	1893
Admission episodes for alcohol-related unintentional injuries (Narrow)	18/19	152.5	146.8	149.6	167	172.9	132.3	132.7	123.8	156.1
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow)	18/19	75.6	49.7	39.1	62.7	53.4	51.3	31.2	55.9	50
Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow)	18/19	49.1	61.7	101.2	96.7	67.5	47.7	41.1	39	62.5
Admission episodes for alcohol-related cardiovascular disease (Broad)	18/19	1219	942	956	992	816	1285	913	817	953
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad)	18/19	412	327	323	458	438	279	214	245	325
Admission episodes for alcoholic liver disease (Broad)	18/19	131.2	95.9	49.2	115.6	83	119.4	76	97.1	107.5
Admission episodes for alcohol-related conditions (Narrow) - Under 40s	18/19	315	325	429	425	370	253	261	289	320
Admission episodes for alcohol-related conditions (Narrow) - 40-64 yrs	18/19	929	742	746	942	705	710	600	575	953
Admission episodes for alcohol-related conditions (Narrow) - Over 65s	18/19	1049	932	1095	1031	907	977	875	759	936

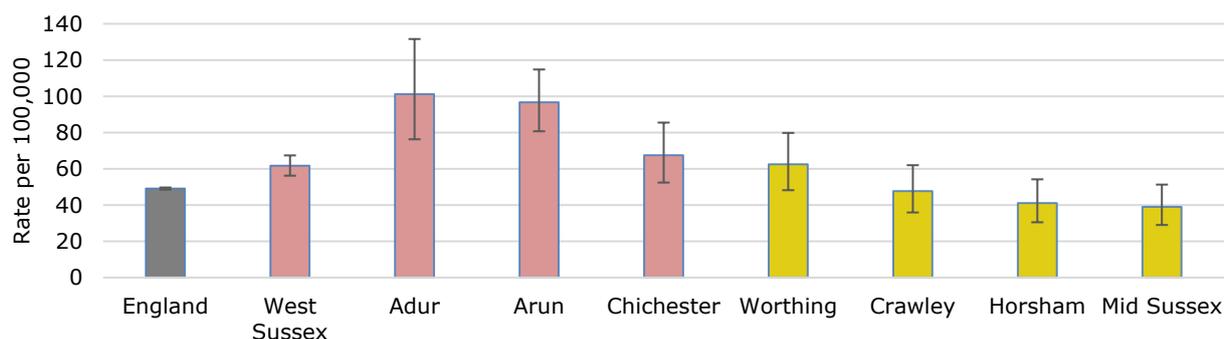
*Red and green indicators are significantly higher or lower than national benchmarks (95% CI).

Source: PHE Fingertips

5.5.4 Self-poisoning

Overall, West Sussex has significantly higher rates of admissions to hospital, where the secondary diagnoses is an alcohol-attributable intentional self-poisoning by exposure to alcohol (62 per 100,000) than national benchmarks (49 per 100,000). However, much of this higher rate can be attributable to Adur and Arun; Chichester is also significantly above national levels. When looking at sex, females in Worthing are also significantly above national levels, whereas males are not.

Figure 5.6, Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow) – 2018/19



Source: PHE Fingertips

5.5.5 Unintentional injuries

In 2018/19, there were 147 admission episodes for alcohol-related unintentional injuries per 100,000 in West Sussex, in line with national benchmarks (153 per 100,000). Locally, only Mid Sussex had a significantly lower rate than England and no unitary authorities were significantly higher, though males in Chichester were significantly higher than the national average (273 per 100,000 compared to 229).

5.6 Deaths related to drug and alcohol use

5.6.1 Alcohol deaths

Years of life lost indicate the contribution of alcohol misuse to premature death. Early death from chronic conditions is disproportionately prevalent in lower socio-economic groups and is likely to place demand on health and social care services prior to death. The death of people of working age will additionally impact on productivity. High rates of alcohol-specific mortality and mortality from chronic liver disease are likely to indicate a significant population who have been drinking heavily and persistently over the past 10 - 30 years (obesity is also a key factor for liver disease).

Broadly speaking alcohol-related deaths make up around 5% of all deaths (PHE, 2017). Of these, about a quarter are alcohol-specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis. The remaining alcohol-related deaths are from conditions partially related to alcohol, roughly two thirds of which are from chronic conditions – e.g. cardiovascular diseases and cancers, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm. The rate of chronic liver disease mortality in the most deprived quintile

(17.6 per 100,000 of the population) is almost double the rate in the least deprived (9.1) - Source: LAPE, PHE).⁸⁰

Locally, the years of life lost due to alcohol-related conditions calculated for 2018 were 715 for males and 322 for females (570-876, and 234-426 at 95% CI). These are lower (but not significantly lower for females), than national benchmarks.

The narrow band alcohol-specific mortality in 2016-18 in West Sussex was 10.6 per 100,000, which has risen to align with national levels in recent years (10.8) and is higher than the regional average (8.9). The broad band alcohol-related mortality for 2018 was 40.4 per 100,000. These levels have been consistently lower than national benchmarks in recent years.

Mortality from chronic liver disease in the under-75s in 2016-18 was 8.4 per 100,000 and where this had been significantly lower than national benchmarks it has risen to similar levels in recent years; it is now significantly higher than regional averages (7.1). Rates for liver disease and for mortality are roughly twice as high for males as for females.⁸¹

5.6.2 Drugs deaths

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the Global Burden of Disease Survey 2013 shows that drug use disorders are now the third ranked cause of death in the 15–49 age group in England. Nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse. Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase over these two years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded to has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others to consider the impact of treatment in addiction to recovery outcomes.⁸²

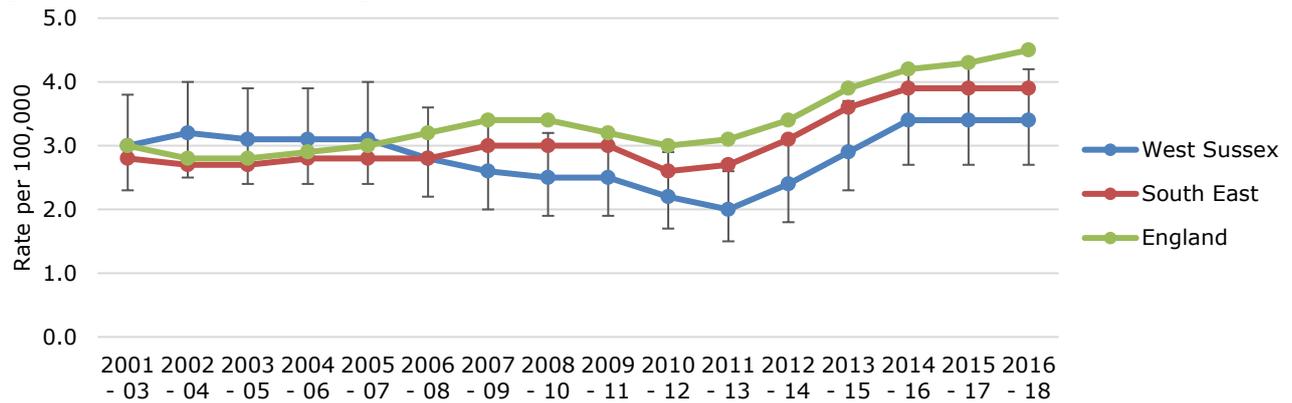
Drug misuse deaths in West Sussex were decreasing steadily from 2005 to 2011, though this was reversed around 2012 and have risen to a higher level than any when in the past two decades. national deaths have increased at a faster pace and West Sussex holds a significantly lower rate of drug misuse deaths than national benchmarks.

⁸⁰ Source: Extract from PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

⁸¹ Source: PHE Fingertips

⁸² Source: Extract from PHE, Fingertips, indicator C19d

Figure 5.7, Deaths from drug misuse (ONS definitions)



Source: PHE fingertips

In an audit of all deaths from drug poisonings (including suicides and medications) for the years 2015-17, there were 123 deaths registered in West Sussex. Of these, 86 were male and 37 were female. Over half of all deaths were considered 'accidental overdoses' and accounted for 58% of male deaths and 43% of female deaths. Females proportionally had more self-administered overdoses and suicides than males. Suicides were attributed to 35 of the 123 deaths.

Drug misuse deaths accounted for 52% of all deaths and 64% of male deaths, whilst only accounting for 24% of female deaths. Half of male deaths (51%) involved controlled substances, compared to one in six female deaths. Two thirds of female deaths occurred with their own prescribed medications.

When considering the 64 drug misuse deaths in isolation, 50 of these involved controlled substances (44 of which were male). When considering the 59 other drug poisoning deaths, 12 were purchased in store or online, and 42 were with their own prescribed medication.

Figure 5.8, Drug misuse and other drug poisonings (2015-17)

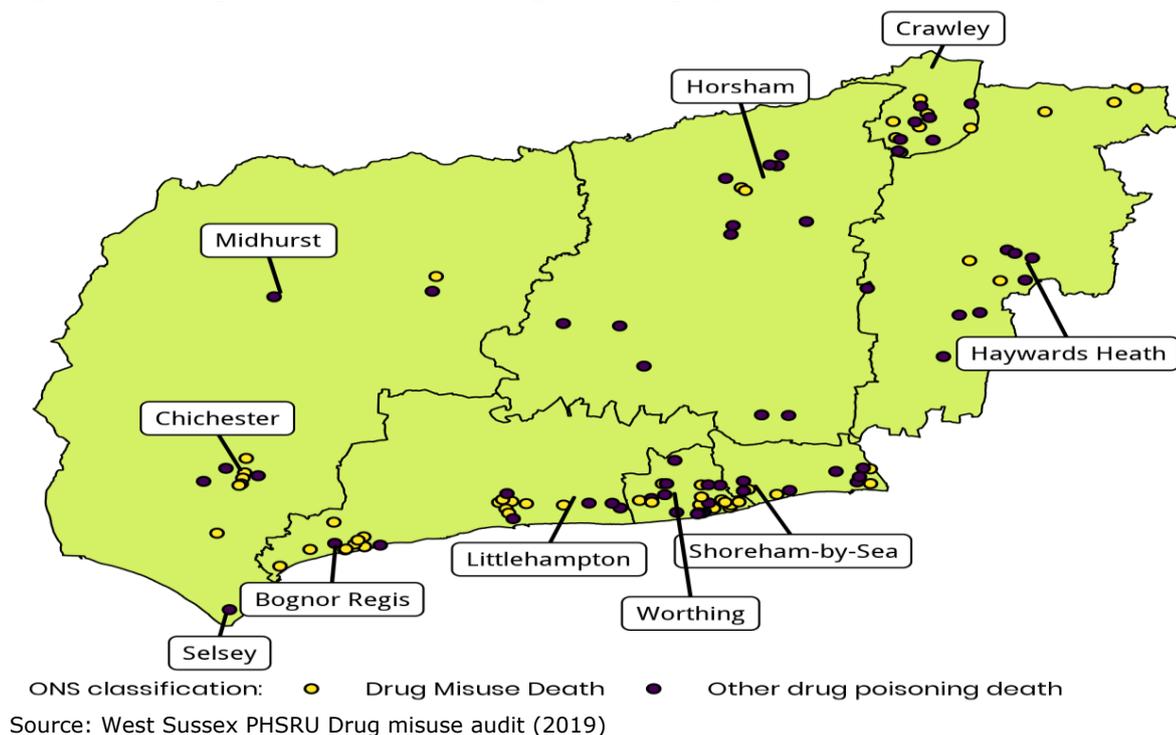


Table 5.2, Groupings of drugs and their occurrence in individual deaths (2015-17)

Broad substance grouping	Drug Misuse Death	
	Occurrence	% of all deaths
Opioid/opiates	57	89%
Ethanol	20	31%
Benzodiazepines	18	28%
SSRIs and SNRIs	10	16%
Stimulants	25	39%
Other/off-label antidepressants	4	6%
Paracetamol and ibuprofen	3	5%
Hypnotic/sedative/z-hypnotics	< 3	3%
Cannabinoids	7	11%
Antipsychotic	3	5%
Other drug/compound	< 3	2%
Antiepileptic	0	0%
Barbiturate	< 3	2%
Novel psychoactive substance	3	5%

Source: West Sussex CC, PHSRU Drug misuse audit (2019)

The West Sussex audit identified a number of themes related to deaths from drug poisonings, which were accepted by the Health and Wellbeing board and Safer West Sussex Partnership.

Figure 5.9, Broad level findings of drug related deaths audit, West Sussex

- Deaths from drug poisoning affect a wide spectrum of residents in West Sussex. Whilst younger men account for a larger proportion, deaths are not attributable to a single cohort or demographic and as such, efforts to reduce early death require actions to be wide reaching and broad.
- Geographic areas have been identified as more concentrated areas of drug misuse deaths and outreach work can be targeted to these areas; though the age of this data should remain a caveat in identifying such areas.
- Resolving the issues of co-occurring mental health problems appear to be a key issue in reducing deaths from drug poisonings across a full spectrum of West Sussex residents.
- Messages around dangers of alcohol mixed with medications or other substances may need to be reconsidered or refocused. Efforts to understand how and why the danger is either not understood or not avoided may help to reduce deaths in the future. This may require assessing individuals for alcohol risks at the point of prescription or dispensing.
- Fatality due to alcohol mixing might be rare, but the risk is heightened when the individual is in a period of low resilience, for which alcohol is a self-medicated relief and consideration of other medication may not come into play.
- Missed diagnosis and barriers around gatekeeping and referrals are an issue of professional training, and were a significant theme running through many of the deaths examined.
- Those known to have engaged with community substance misuse services were shown to have a range of complex emotional and mental health problems, which may make treatment more difficult, particularly if staff do not have the skills or resources to deal with complex cases.
- Opiates are the primary drug group, in both misuse and other poisonings, but multiple substances (three or more) were found in more than half of all deaths. Opiates tended to involve heroin in drug misuse deaths and prescribed painkillers in other drug poisonings.
- The step-down between tier 4 and tier 3 services may be too steep, for substance addiction and for mental health patients going into less focused community-based support.
- Many of the deaths examined were of people who needed focused help to support their everyday life and recovery.
- Most of these cases were highly complex and person-specific and were not driven by a single clear solvable or targetable issue. Addressing those issues will require a more holistic and integrated culture of prevention and resilience building, concerning many partnering agencies.
- It may be necessary to repeat focused audit work like this in the future, to examine how policy and public services have adapted to these findings. To allow for ways of working to take hold, this should not occur for several years.

Source: West Sussex PHSRU Drug misuse audit (2019)

5.7 Alcohol and drug-related crime

The majority of Sussex police drug activity involves cannabis (roughly three quarters). Locally areas of higher cannabis-possession crime occur in Crawley and Worthing boroughs and also in Arun district. These areas also account for the majority of non-cannabis drug possession.

Table 5.3a, Police recorded crimes. Possession of controlled drugs (Cannabis only)

Period	Pan-Sussex	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
16/17	2150	1045	94	173	106	309	91	101	171
17/18	1933	949	87	123	111	277	93	89	169
18/19	2257	1170	51	160	86	389	153	115	216
19/20	2653	1347	87	220	100	341	158	142	299

Source: Home Office, Police recorded crime and outcomes open data tables. Sussex police data unassigned to community safety partnership: 16/17: 19, 17/18: 21 18/19: 19, 19/20 35.

Table 5.3b, Police recorded Crimes. Possession of controlled drugs (excl. Cannabis)

Period	Pan-Sussex	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
16/17	852	381	65	70	33	110	31	24	48
17/18	789	34	79	57	36	93	24	12	63
18/19	867	380	15	77	41	119	27	14	87
19/20	931	397	16	82	33	112	26	26	102

Source: Home Office, Police recorded crime and outcomes open data tables. Sussex police data unassigned to community safety partnership: 16/17: 12, 17/18: 9, 18/19: 9, 19/20: 12.

Public Health England have an outcome indicator for the proportion of adults released from prison (into the local authority area) with substance misuse treatment need, who go on to engage in structured treatment interventions in the community within three weeks of release. Nationally, roughly 30-35% of those with substance misuse issues engage with treatment within three weeks. This is significantly lower in West Sussex, where point estimates suggest approximately 20% are engaging. In the South East, only Slough and Oxfordshire LAs had lower percentages in 2018/19.

Table 5.4, Adults with a substance misuse treatment need who successfully engage in community-based treatment following release from prison

Period	West Sussex			South East	England
	Count	Value	95% CI range		
2015/16	43	21.3%	16.2% - 27.4%	29.4%	30.3%
2016/17	42	24.7%	18.8% - 31.7%	28.9%	30.3%
2017/18	23	14.7%	10% - 21.2%	32.1%	32.1%
2018/19	22	20.0%	13.6% - 28.4%	34.1%	34.2%

Source: PHE fingertips

Community Level Impacts of Substance Misuse, Key Summary:

The occurrence of mental health conditions among people with substance misuse problems is very common and this two-way relationship is complex. Of new presentations to alcohol treatment in 2019/20, 54% were identified as having a mental health treatment need. Of those, roughly 22% of males and 16% of females were not receiving any professional support for assessed mental health problems. Of the adults who entered drug treatment in 2019/20, 60% were assessed as having a mental health treatment need. Of those, about 32% of males and 21% of females were not receiving any professional support for assessed mental health problems.

Tobacco use is far higher amongst those with substance dependencies and many reasons exist for this increased use. A considerable number of those using services quit smoking during treatment, but others also take up smoking to offset the loss of the other substance. Very low numbers of service users in West Sussex are offered smoking cessation.

Sexual health providers are working closer with substance misuse providers to improve joint working, including opportunistic access to sexual health for drug and alcohol clients, and having substance misuse services on key stakeholder lists for the strategy group.

Preventable bacterial infections are increasing, and the cause is likely to include the ageing populations of PWID with poorer vein and skin health, changes in injection practices with recent increases in groin injections, increasing homelessness, and likely conditions of poorer general hygiene and unsterile injecting. Use of personal injecting kits is encouraged and despite low HIV levels, risks from HIV and Hepatitis B and C continue.

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Locally, admission episodes for alcohol-related conditions have been increasing and there is a need to explore and address the increased alcohol-related health outcomes and hospital admissions in the coastal towns of West Sussex, which are above national averages, and particularly so for females aged under 40 years.

Broadly speaking, alcohol-related deaths make up around 5% of all deaths nationally and increasing mortality rates in West Sussex are now higher than regional averages, and in line with national averages. Drug use disorders are the third highest cause of death in the 15–49 age group in England.

Locally West Sussex has lower rates of drug death than national averages. A review into local drug-deaths identified a range of factors inhibiting successful recovery, including mental health issues; diagnosis, gatekeeping and systems issues; education around safe drug use (including medications); and complex individual lives not fitting into fixed support systems.

Roughly three quarters of drug-related crime involves cannabis and drug crime is more concentrated in Crawley, Worthing and Arun. West Sussex also performs poorly compared to the South East in engaging prison leavers in drug treatment within three weeks.

6. Alcohol and Drug Treatment Service Users

This section covers the data relating to residents using drug and alcohol services in the community. Understanding how these locally commissioned treatment services are supporting local residents can help commissioners and providers to adapt and refine service provision, as well as expanding partnership opportunities. Much of this data is taken from the National Drug Treatment Monitoring System (NDTMS), which at time of writing included data up to 2018/19.

Key headings:

- 6.1 Numbers of service users in treatment services
- 6.2 Characteristics of service users in alcohol treatment services
- 6.3 Characteristics of individuals in drug treatment services
- 6.4 Harm reduction interventions
- 6.5 Meeting estimated need for alcohol and drug users
- 6.6 Referral routes into treatment and waiting times
- 6.7 Treatment settings
- 6.8 Length of treatment and retention
- 6.9 Successful and unsuccessful treatments

The combined benefits of drug and alcohol treatment nationally amount to £2.4bn every year, resulting in savings in areas such as crime, quality-adjusted life years (QALYs) improvements and health and social care. Quality-adjusted life years (QALYs) are measures of life expectancy and quality of life used in health economic evaluations and resource allocations.

Public Health England estimates that alcohol treatment reflects a return on investment of £3 for every £1 invested, which amounts to £26 over 10 years. Drug treatment reflects a return on investment of £4 for every £1 invested, which amounts to £21 over 10 years.⁸³ Excellent drugs and alcohol treatment service provision alone is insufficient to see an improvement in recovery in the county. It is important that a multi-level approach is taken to improving drug recovery. There needs to be efforts made to ensure that people are aware they may need a treatment and are aware and able to access the treatment and service most appropriate for them.

⁸³ Source: PHE guidance, [Alcohol and drug prevention, treatment and recovery: why invest?](#)

A PHE 'Health Matters' edition⁸⁴ explored ways to improve access and retention for services and identified the following mechanisms:

- Outreach programmes
- Needle and syringe programme
- Accessible locations and flexible opening times
- Open sessions and sessions restricted to particular groups and issues
- Individualised and welcoming communications, and reminding patients of appointments and checking how they are doing after they leave treatment
- Providing transport and childcare
- Key workers skilled in building a therapeutic alliance and in motivational techniques, knowing when to take the lead and when to take a back seat
- Ensuring effective and supported pathways to treatment from prison

The UK government's 2017 Drugs Policy report included a section on physical and mental health in which they included the importance of preventing blood borne viruses (via needle exchange programmes and vaccination) and overdose awareness response training.⁸⁵ In addition to this, the UK Health and Social Care Select Committee recommended in 2019 that effective drugs policy required a focus on health and harm reduction, through needle and syringe exchange programmes, naloxone, drug consumption rooms and heroin assisted treatments.⁸⁶

The benefits to West Sussex residents of ensuring there is a robust harm reduction offering available would be to:

- Improve the health of and reduce the risks to health of individual drug users.
- Stabilise the lives of drug users
- Reduce the burden on health care system and criminal justice systems
- Encourage those into drug recovery treatment
- Reduce the wider burden of drug harms on the wider community and society.

6.1 Numbers of service users in treatment services

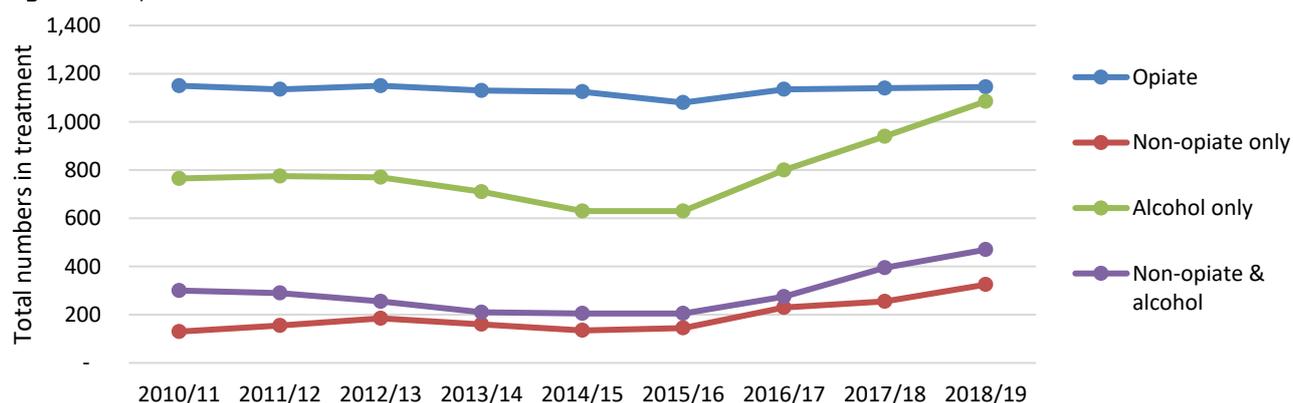
The number of opiate users seeking treatment in West Sussex has remained relatively flat (around 1,150) each year. The number seeking treatment for non-opiates has doubled in recent years, from roughly 150 to 300 each year. Alcohol service use has also increased notably, nearly doubling from roughly 650 to 1,100 per year.

⁸⁴ Source: PHE, [Health matters: preventing drug misuse deaths](#) (2017)

⁸⁵ Source: UK Home Office, [Drug Strategy 2017](#) (2017)

⁸⁶ Source: UK Parliament, [Health and Social Care Committee](#) (2019)

Figure 6.1, All service users in treatment in West Sussex



Source: NDTMS

6.2 Characteristics of service users in alcohol treatment services

6.2.1 Demographic characteristics

There were 1,085 individuals receiving alcohol treatment in West Sussex in 2018/19. Of these, 58% were males and 42% were females, which roughly aligns with national averages of 60% and 40% respectively. Regarding age, West Sussex drug service users were slightly older than national averages.

Table 6.1, Age and sex of service users for alcohol treatment in 2018/19

Age	West Sussex				National			
	Count	%	Males	Females	Count	%	Males	Females
18-29	101	9%	8%	11%	6,538	9%	8%	10%
30-39	212	20%	20%	19%	16,789	22%	22%	23%
40-49	309	28%	28%	30%	22,806	30%	30%	30%
50-59	331	31%	32%	28%	20,275	27%	27%	26%
60-69	103	9%	10%	9%	7,441	10%	10%	10%
70-79	27	2%	3%	2%	1,588	2%	2%	2%
80+	2	0%	0%	0%	118	0%	0%	0%

Source: NDTMS

Of those in treatment in 18/19, 724 were new presentations (67% of all in treatment). Of these, 86% were White British, 7% classified as 'Other White', 1% as White Irish, 1% as Black, <1% as Asian and 3% held missing data. Ninety three percent were born in the UK, 1% in Poland, 1% in Ireland, 1% in South Africa and 1% in Lithuania. No other countries were referenced in this data.

Regarding religion, 53% identified with no religion, 25% as Christian, 1% as Buddhist and <1% as Muslim; 17% of individuals had incomplete data.

Regarding sexuality, 84% of individuals identified as heterosexual, 2% as gay/lesbian, 1% as bisexual and 8% as unstated or unknown; a further 4% had incomplete data.

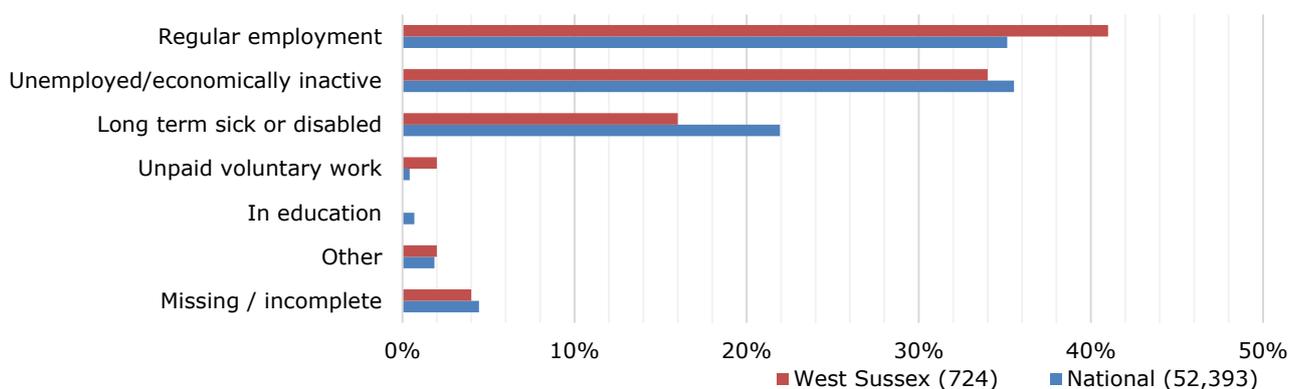
Regarding disability, 67% self-identified as having no disability, 15% as having a behavioural or emotional disability, 7% as having a mobility or gross motor disability, 4% as having a learning

disability, and 5% were unstated or unknown; a further 1% had incomplete data. These tally to reveal that 205 new service users self-identified as having at least one disability (28%).

6.2.2 Employment

Improving job outcomes is key to sustaining recovery and requires improved multi-agency responses with Jobcentre Plus and the Work and Health Programme providers. It is commonplace to include outcomes in service specifications regarding improved employment rates in service leavers (PHOF indicator 2.15). In West Sussex, 41% of 724 new service users identified as being in regular employment at the start of treatment. This is higher than national benchmarks of 35%.

Figure 6.2, Employment status for new alcohol service users at start of treatment (2018/19)



Source: NDTMS

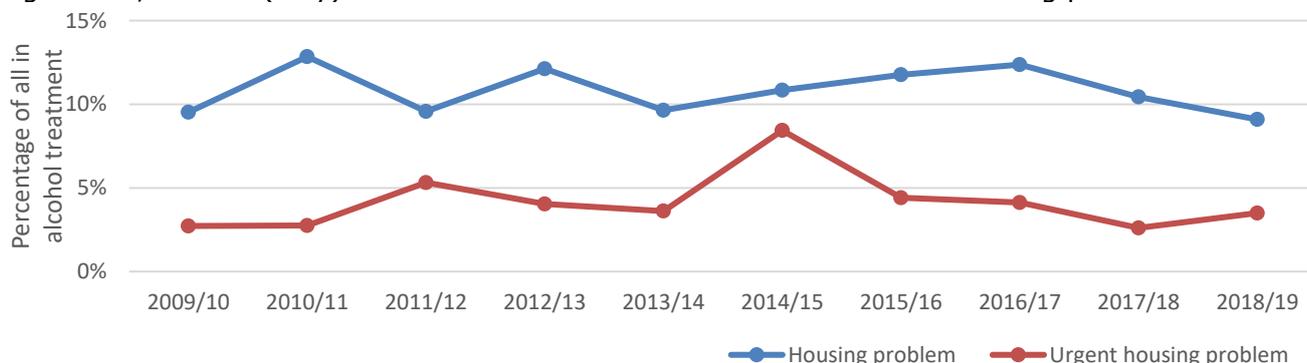
Upon service exit reviews, West Sussex service users who had a planned exit from treatment (n=371) were asked if they were in employment at the end of their treatment. Of those having a planned exit review, 61% were not working at the time of starting treatment, which fell to 55% at the end of treatment. West Sussex service users were also more likely to be in employment at service exit than the national averages, with 45% of individuals in work, compared to 36% nationally, in part reflecting the relatively good employment in the county compared with many other areas.

6.2.3 Housing and accommodation

A safe, stable home environment enables people to sustain their recovery. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and addressed: from statutory homeless, single homeless people, rough sleepers to those at risk of homelessness.

In West Sussex (2018/19), 67 alcohol service users (9%) were identified as having a housing problem and a further 27 (4%) as having an urgent housing problem.⁸⁷ Over time, this proportion has remained roughly steady and compares to 7% and 3% (respectively) at a national level.

Figure 6.3, Alcohol (only) service users in West Sussex with identified housing problems



Source: NDTMS

6.2.4 Drinking levels

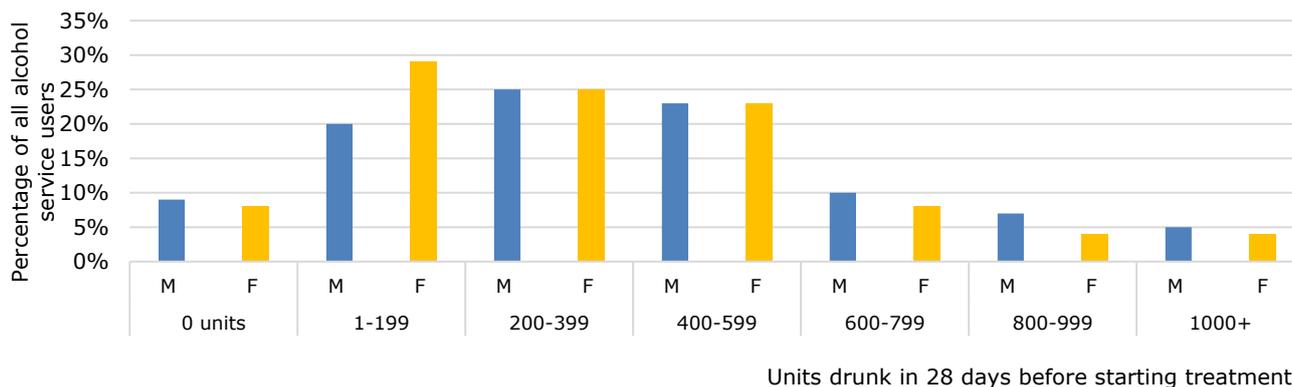
Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. Drinking levels can be used as a rough proxy for level of dependence and levels of alcohol health risk. The NDTMS releases drinking levels in treatment, as they may be useful in understanding which groups of clients are receiving treatment and whether those with the highest levels of harm are receiving effective interventions. There is a strong association between levels of consumption and severity of dependence, but they are not equivalent. In general, women are likely to become dependent at lower levels of consumption than men for example.⁸⁸

This following show the number of units consumed by people in treatment in the 28 days prior to commencing treatment. In West Sussex 22% of males and 16% of females starting treatment reported drinking at least 600 units of alcohol in the preceding 28 days.

⁸⁷ Housing problems are defined by NDTMS as those who are staying with friends/family as a short-term guest; using night winter shelters; have direct access to short stay hostels, short term bed and breakfast or other hotel; placed in temporary accommodation by local authority; or are squatting. Urgent housing needs are defined as those who live on streets/rough sleeper; uses night shelters (night-by-night basis)/emergency hostels; or are sofa surfing/sleeping on different friend's floor each night.

⁸⁸ Source: Extract from PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

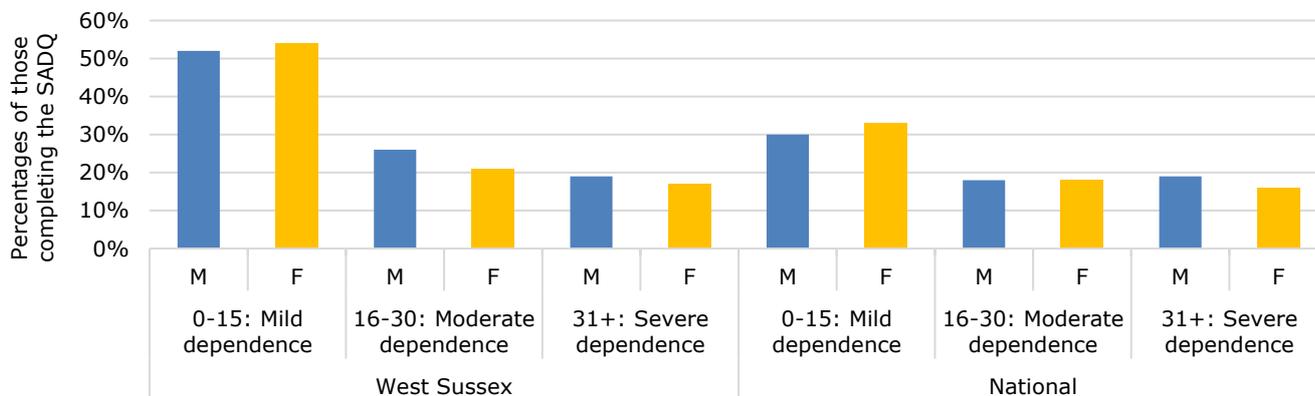
Figure 6.4, Units consumed in the 28 days prior to entering West Sussex treatment, by sex



Source: PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data⁸⁹

The Severity of Alcohol Dependence Questionnaire (SADQ) is not completed by all new service users but of the 392 males and 290 females new to treatment in 2019/20, roughly half are assessed as having mild dependence. With 6% failing to record a score, it is possible that some of these scores are different for the full service user cohort. Rates of dependence are difficult to compare with national benchmarks, as one in three service users nationally do not record a score, but scores have been similar in previous years.

Figure 6.5, Severity of alcohol dependence questionnaire (SADQ) scores for new service users



Source: PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

6.2.5 Concomitant alcohol and drug use

The needs of those alcohol service users who also have drug misuse problems can bring additional risk to individual safety and extra consideration needs to be given to what additional support they may require. For example, alcohol has been shown locally to increase the likelihood of death from

⁸⁹ Consumption is based on drinking levels over the 28 days prior to assessment. There will be some moderately or severely dependent adults who have stopped or reduced consumption prior to treatment (for example in hospital or prison) so will appear in the lowest category.

drug overdose.⁹⁰ Of all alcohol service users in West Sussex in 2019/20 (1,730), 58% were seeking support for only alcohol dependence. Four percent were also receiving support for opiate dependence; 27% were also for non-opiates; and 11% for alcohol, opiates and non-opiates; – 11% cited crack, 18% cited cocaine, and 13% cited cannabis. These proportions are roughly in line with national averages.

6.3 Characteristics of individuals in drug treatment services

6.3.1 Demographic characteristics

There were 1,946 individuals receiving drug treatment in West Sussex in 2018/19. Of these, 70% were males and 30% were females, which roughly aligns with national averages of 73% and 27% respectively. West Sussex does have more younger service users than nationally, (23% under 30 years, compared to 17% nationally).

Table 6.2, Age and sex of service users for drug treatment in 2018/19

Age	West Sussex				National			
	Count	%	Males	Females	Count	%	Males	Females
18-29	453	23%	20%	31%	32,105	17%	16%	20%
30-39	646	33%	32%	36%	68,175	35%	34%	38%
40-49	542	28%	31%	22%	62,330	32%	34%	29%
50-59	252	13%	14%	9%	25,503	13%	14%	11%
60-69	52	3%	3%	2%	4,212	2%	2%	2%
70-79	1	0%	0%	0%	345	0%	0%	0%
80+	0	0%	0%	0%	26	0%	0%	0%

Source: NDTMS

Of those in treatment in 18/19, 928 were new presentations (48% of all in treatment). Of these, 86% were White British, 3% classified as 'Other White', 1% as White Irish, 1% as Black, 1% as Asian and 4% held missing data. Ninety three percent were born in the UK, 1% in Mauritius, 1% in Ireland, 1% in Portugal and <1% in Lithuania. No other countries were referenced in this data.

Regarding religion, 56% identified with no religion, 14% as Christian, 1% as Muslim and <1% as Buddhist; 25% of individuals had incomplete data.

Regarding sexuality, 75% of individuals identified as heterosexual, 2% as gay/lesbian, 2% as bisexual and 8% as unstated or unknown; a further 13% had incomplete data.

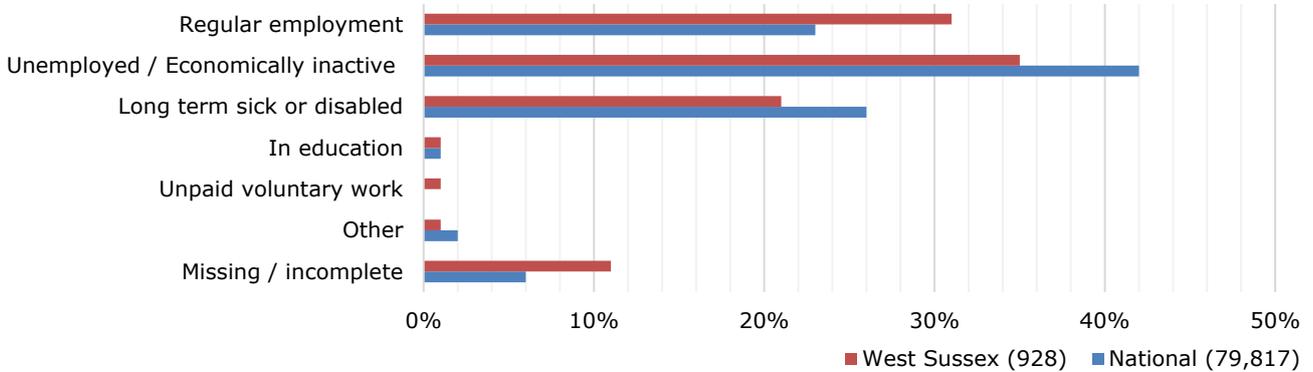
Regarding disability, 56% identified as having no disability, 20% as having a behavioural or emotional disability, 7% as having a learning disability, 6% as having a mobility or gross motor disability, and 4% were unstated or unknown; a further 9% had incomplete data. These tally to reveal that 303 new service users were identified as having at least one disability (33%).

⁹⁰ Source: West Sussex PHSRU, [West Sussex Drug Related Deaths](#) 2015-17 (2019)

6.3.2 Employment

In West Sussex, 31% of 928 new drug service users identified as being in regular employment at the start of treatment. This is higher than national benchmarks of 23%.

Figure 6.6, Employment status for new drug service users at start of treatment (2018/19)



Source: NDTMS

Nationally, those who left treatment before completion ('unplanned exit') were more likely to be 'not working' at the start of their treatment (82%) and upon their unplanned exit (83%), than those who completed their treatment (67% and 64% respectively). From this we can see that worklessness is an indicator of increased likelihood to leave treatment without completion. – Comparisons for West Sussex are not possible due to small numbers.

Upon 'planned exit' reviews, 49% of West Sussex drug service users (n=240) were in some form of employment, compared to 36% nationally. Of these those having a planned exit review, 45% were working at the time of starting treatment.

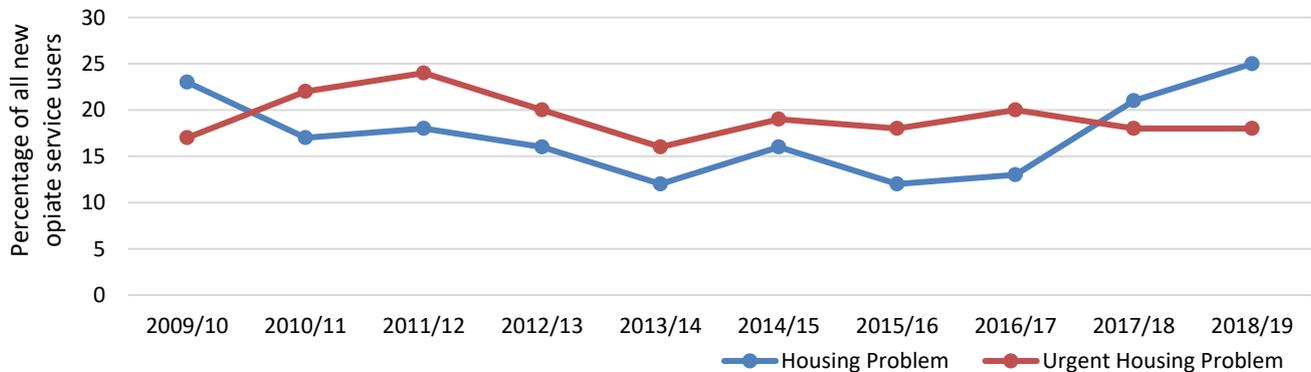
6.3.3 Housing and accommodation

A safe, stable home environment enables people to sustain their recovery. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and picked up: from statutory homeless, single homeless people, rough sleepers to those at risk of homelessness. In West Sussex (2018/19), 171 drug service users (18%) were identified as having a housing problem and a further 88 (9%) as having an urgent housing problem. – A further 82 (9%) were classed as 'other', due to data-collection issues, making them unknowns.⁹¹

⁹¹ Housing problems are defined by NDTMS as those who are staying with friends/family as a short-term guest; using night winter shelters; have direct access to short stay hostels, short term bed and breakfast or other hotel; placed in temporary accommodation by local authority; or are squatting. Urgent housing needs are defined as those who live on streets/rough sleeper; uses night shelters (night-by-night basis)/emergency hostels; or are sofa surfing/sleeping on different friend's floor each night.

Over the past several years, the percentage of opiate service users in West Sussex with a housing problem has increased to levels not seen since 2009. In 2018/19, 25% of opiate service users had a recognised housing problem, and a further 18% had an urgent housing problem. This compares to 16% and 17% (respectively) at a national level.

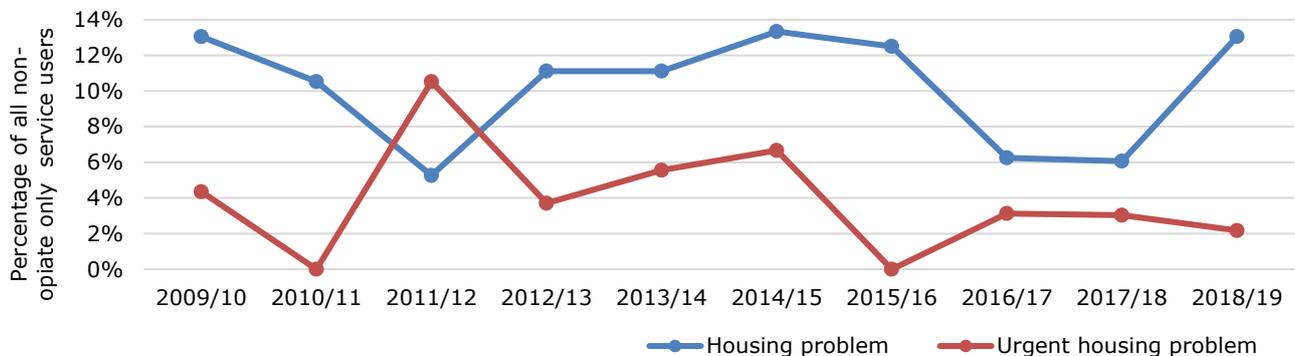
Figure 6.7, Opiate service users in West Sussex with identified housing problems



Source: NDTMS

For non-opiate (only) services users in West Sussex, the percentage with recognised housing problems have fluctuated between 10% and 20% over the past decade, and inconsistencies are likely due to the small numbers in this group. This compares to 11% and 4% (respectively) at a national level.

Figure 6.8, Non-opiate (only) service users in West Sussex with identified housing problems



Source: NDTMS

6.3.4 Prescription and over-the-counter medicine

People can become dependent on medications prescribed to them, or to medications they purchase from licensed vendors. Beyond this some people can use pharmaceutical drugs recreationally, or where they are not needed therapeutically. In both cases these would fit the term 'misuse'.

When viewed nationally, people are being prescribed more medicines and for longer, than was seen ten years ago; specifically, Gabapentinoids and antidepressants. However, recently

benzodiazepine and opioid prescriptions have fallen.⁹² In 2017/18 the following prescriptions were observed:

- Antidepressants - 7.3 million individuals (17% of the population)
- Opioid pain medicines (excluding for treatment of cancer pain) - 5.6 million (13%)
- Gabapentinoids - 1.5 million (3%)
- Benzodiazepines - 1.4 million (3%)
- Z-drugs⁹³ - 1.0 million (2%)

Roughly one in four people receive one or more of these types of medications, and despite the fact that only antidepressants are licensed for long term use, a considerable number of people received prescriptions for the other classes of medications for at least a year. Antidepressants are associated with withdrawal, but the four other classes are associated with a risk of both dependence and withdrawal. Risk factors for opioid dependence were higher initial opioid doses, prior mental health problems and prescriptions that lasted more than 90 days.

The PHE review made a number of recommendations including increasing availability and use of data on prescribing medications that can cause dependence and withdrawal, enhanced clinical guidelines, improving patient information, improving support available from the healthcare system for patients who experience dependence or withdrawal and further research into the treatment of dependence and withdrawal from prescribed medicines.

The Faculty of Pain Medicine estimate that 8-12% of long term prescribed opioid users would currently, or in the past, meet the criteria for an opioid use disorder.⁹⁴ They also highlight an 'adverse selection' phenomenon, where patients who have co-morbid mental health disorders are more likely to receive opioid prescriptions for pain, and are at higher risk of using problematic high doses and in addition have a higher chance of being prescribed other psychotropic medications such as benzodiazepines.

Benzodiazepines, when obtained illicitly and misused by high-risk opioid users can result in morbidity and mortality, and are often implicated in drug related deaths.⁹⁵ Many high risk users can be prescribed benzodiazepines initially with a therapeutic aim but then often go on to misuse them. Misuse involves self-medicating psychiatric conditions, opioid withdrawal symptoms and the side effects of other substances. Additionally, they can enhance the effects of opioids.

In West Sussex, there were 85 individuals in treatment for prescription-only medicines (POM) or over-the-counter medicines (OTC), and a further 212 who were in treatment for these and also illicit drugs. These represent 4% and 11% of the total drug treatment cohort, respectively. These

⁹² Source: Public Health England, [Dependence and withdrawal associated with some prescribed medicines](#) (2019)

⁹³ Z-drugs are a class that are mainly used to treat sleep problems as an alternative to Benzodiazepines; they work by and calming brain activity (potentiating GABA activity).

⁹⁴ Source: Faculty of Pain Medicine, [Terminology and prevalence](#) (2020)

⁹⁵ Source: EMCDDA, [The misuse of benzodiazepines among high-risk opioid users in Europe \(Perspectives on drugs\)](#) (2018)

align with national averages. Of those with no illicit drug use, 54% were males and 46% females; of those with other illicit drug use, 67% were males and 33% females.⁹⁶

6.3.5 New psychoactive substances (NPS) and 'club drugs'

Fewer than ten people in treatment in West Sussex cited using club drugs with opiates and only 31 cited using club drugs with other illicit non-opiates; such small numbers therefore makes analysis difficult. Nationally, however, 2% of opiate service users and 7% of non-opiate service users were also cited using 'any of the following club drugs' (Table 6.3). Most adult treatment activity still centres around opiate use, and these individuals generally face a more complex set of challenges. In comparison, non-opiate-using, adult club drug users typically have better personal resources – in the form of employment, relationships, accommodation – that can support their treatment and recovery.

Table 6.3, New psychoactive substances reported by new treatment entrants, nationally

Drug type	Adults new to treatment and citing opiate use		Adults new to treatment and citing non-opiate use	
	Count	Percentage	Count	Percentage
Ecstasy	45	5%	818	28%
Ketamine	77	8%	1,063	37%
GHB/GBL	19	2%	332	11%
Methamphetamine	32	3%	435	15%
Mephedrone	24	3%	86	3%
NPS other	763	80%	528	18%
Predominantly cannabinoid	427	45%	258	9%
Predominantly stimulant	36	4%	68	2%
Predominantly sedative/opioid	27	3%	17	1%
Predominantly hallucinogenic	35	4%	31	1%
Predominantly dissociative	18	2%	28	1%
Other	223	24%	133	5%

*Adults may be use more than one drug and are counted once for each drug they cite; total percentages are for those citing any club drug use

Source: PHE, West Sussex Adults – drugs commissioning support pack 2021-22: key data

6.3.6 Pharmacological interventions

Pharmacological interventions are widely used to assist with drug treatment. In West Sussex, 2019/20, 553 individuals were prescribed methadone (50% of all those receiving prescriptions), compared to 52% nationally; 238 were prescribed supervised buprenorphine (22% of all those receiving prescriptions, compared to 15% nationally); and 2% were prescribed supervised buprenorphine and naloxone, in line with national averages. Local pharmacological interventions have increased significantly from the previous year (2018/19), where 42% received methadone and 18% received buprenorphine.⁹⁷

⁹⁶ Source: NDTMS

⁹⁷ Source: PHE, West Sussex Adults – drugs commissioning support pack 2021-22: key data

6.4 Harm reduction interventions

As outlined at the beginning of this section, there are several different harm reduction approaches currently employed in West Sussex, which are contextualised below.

6.4.1 Naloxone availability and training in its administration

Providing naloxone and training of its use to drug users, family, friends and hostel workers so that lifesaving treatment of an overdose can be treated. The provision of naloxone across the country varies; however, studies have shown that take-home naloxone programmes do reduce the overdose mortality among both programme participants and in their wider community, and additionally there are a low rate of adverse events.⁹⁸

In West Sussex, Naloxone is distributed across the county and the majority of this activity has been in Worthing, Arun and Crawley. Data are incomplete for 2020/21, though quarterly figures are shown next to the preceding quarter (Q4) for 2019/20.

Table 6.4, Take Home Naloxone kits dispensed by providers in the community

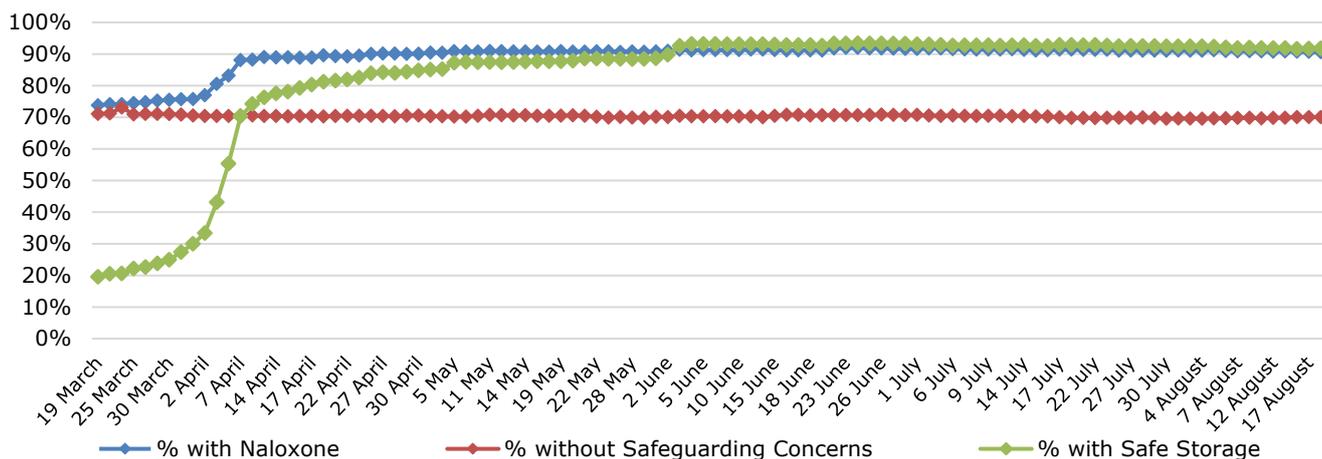
Locality	2016-17	2017-18	2018-19	2019-20	2019-20 (Q4)	2020-21 (Q1)	Total
Adur	21	20	23	10	5	1	80
Arun	148	132	135	94	25	21	555
Chichester	64	43	71	47	14	34	273
Crawley	97	129	146	68	15	6	461
Horsham	37	41	53	35	5	4	175
Mid Sussex	51	37	57	30	3	3	181
Worthing	157	161	175	84	24	44	645
All Pharmacies*	22	28	7	18	4	11	90
West Sussex total	597	591	667	386	95	124	2,460

*Excludes most recent data (from June onwards) which is not currently available
Source: Change Grow Live (provider) performance data (2020)

By May/June of 2020, roughly 95% of known opiate users were being supplied with Naloxone and safe storage kits. It is implied therefore that we have reached a saturation in the community, which explains the reduction in units supplied for 2019/20. Of note is the increase in these percentages during April 2020 (during the national Covid-19 lockdown). This is explored in Section 8.

⁹⁸ Source: McDonald, Strang [Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria](#) (2016)

Figure 6.9, Provision of Naloxone and safe storage kits and those without safeguarding concerns



Source: CGL provider data (2020)

6.4.2 Needle and syringe programmes

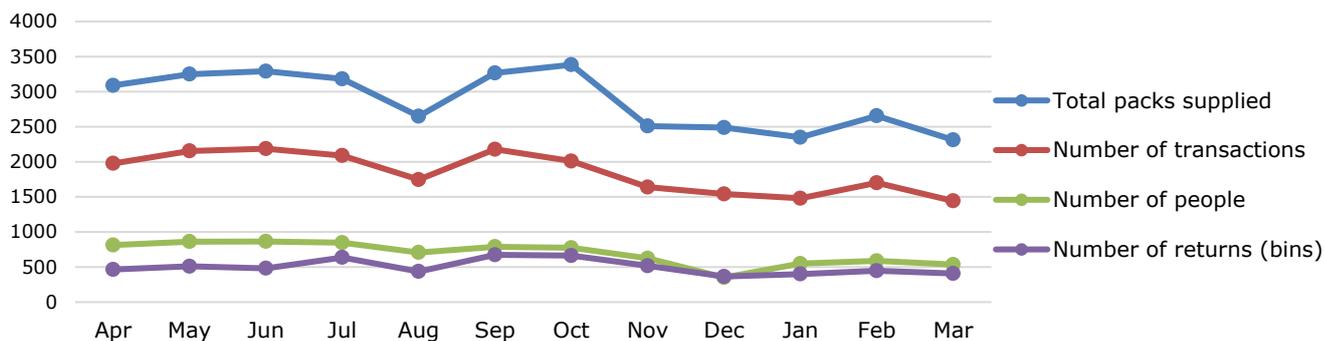
Injecting drug users are at higher risk of contracting HIV, hepatitis B and hepatitis C as well as other bacterial infections as a result of unsafe injecting practises. Needle and syringe programmes reduce harm by preventing users from sharing needles and provide a location where key information, resources and advice can be distributed from.

NICE have provided clear guidance on needle and syringe programmes and have specified standards that should be met. These include that an assessment of need for the programmes should consider various groups of people who include people who inject drug who already use the programmes and those that don't, their families and carers, frontline groups, under-represented drugs, frontline communities and additionally local communities should be consulted. Local estimates can help plan services including the incidence of infections relating to drug use, overdoses and other problems related to IV drug use, rates of poly-drug use, under 18s involved, occasional users, other groups such as MSM, ex-prisoners and homeless people. Local services should aim to oversupply to individuals, so that risks of running out are minimised. Services should be coordinated to ensure testing for blood borne viruses and the services should be available at the right time and place to meet needs. Staff distributing equipment should be available to provide information and advice, and staff should be vaccinated against hepatitis B. Services should be monitored with data on number of packs distributed collected at a minimum.⁹⁹

Locally, West Sussex services have supplied between 500 and 900 people each month with injecting packs. It is not known if some individuals account for many transactions or if transactions are roughly equal per person.

⁹⁹ [NICE Needle and syringe programmes overview](#)

Figure 6.10, West Sussex Needle and Syringe programme 2019/20



Source: West Sussex provider data (2020)

Note: Regarding the recent national lockdown (for Covid-19) we note a reduction of transactions & people during the March, though this doesn't automatically translate to reduction in need. Service leads are continuing to monitor this in as data are released, but informal enquiries across providers have shown that this is not an immediate gap which requires addressing. When data for quarters 1 and 2 are released it will be possible to compare these with previous years.

6.4.3 Drug consumption rooms

These are rooms in which intravenous drug users can go to inject their drugs in sterile environment under supervision. They are politically contested and implementation in the UK would currently be illegal, under UK law.¹⁰⁰ The first drug consumption room was opened in Zurich, Switzerland 30 years ago and since then drug consumption rooms have opened in Germany, Netherlands, Spain, Norway, Luxembourg, Denmark, France, Australia and Canada. Many other countries are also considering their introduction but, in the UK, and in other countries where drug possession is illegal everyone involved could be arrested.

There are strongly opposing views on drug consumption rooms held, with some experts arguing that there is consistent and compelling evidence that the rooms reduce harms and any benefits far outweigh risks. The European Monitoring Centre for Drugs and Drug Addiction's 2018 report concluded they offer a wide range of benefits and there is no evidence that they increase drug use or frequency or affect local crime rates. However, there are many critics, some who argue that the evidence is of limited quality and predominantly done out of limited locations. Critics also argue a more effective method in reducing drug harm would be increasing provision of harm reduction strategies that have a strong evidence base and are already widely used such as needle exchange programmes, opioid substitution treatment and drug treatment.

¹⁰⁰ Source: NICE, [Needle and syringe programmes, Public health guideline](#) (2014)

Despite the fact drug consumption rooms would currently be illegal in the UK and other countries a number do exist unofficially, including in the UK.¹⁰¹

6.4.4 Heroin Assisted Treatment Centres

These share some similarities with drug consumption rooms, however, people who visit these receive prescribed heroin, where other treatments have failed. In the UK, two centres, one in Glasgow and a second in Cleveland were given licenses to open in 2019.¹⁰² The evidence for these was primarily taken from a Randomised Injectable Opiate Treatment Trial (RIOTT). In the study, across three locations in the UK, drug users refractory to conventional treatment were randomised into 3 groups: supervised injectable heroin, supervised injectable methadone or oral methadone. They found that at 26 weeks 80% of all participants remained on allocated treatment: with 88% on injectable heroin versus 81% on injectable methadone and 69% on oral methadone. They looked at the numbers who achieved over 50% of urine samples negative for street heroin and found the percentage to be 66% in those on injectable heroin versus 30% on injectable methadone and 19% on oral methadone. Their studies showed that for people less willing to engage with other drug treatment, treatment with injectable heroin can reduce their street heroin use.¹⁰³

In total 6 different RCTs across Europe evaluating injectable heroin treatment have all found that compared to oral methadone substitution, treatment with injectable heroin treatment brings about greater reduction in illicit heroin use. Additionally, overall, they also identified that patients undergoing SIH treatment experienced significant physical and mental health improvements compared to patients receiving conventional oral substitution prescribing; however, one negative outcome was that there were more serious adverse cardio-respiratory effects were reported occurring in patients receiving SIH than in those receiving oral methadone.¹⁰⁴ Further to this, the cost per person over the year is estimated at between three and ten times more expensive, depending on application; around £6,500 per person per annum in 2006.¹⁰⁵

¹⁰¹ Source: Newman, [Could drug consumption rooms save lives?](#) (2019)

¹⁰² Source: Newman, [Could drug consumption rooms save lives?](#) (2019)

¹⁰³ Source: King's College London, [Randomised Injectable Opiate Treatment Trial](#) (2010)

¹⁰⁴ Source: EMCDDA, [New heroin-assisted treatment](#) (2012)

¹⁰⁵ Source: Harm Reduction Journal, [Methodology for the Randomised Injecting Opioid Treatment Trial \(RIOTT\)](#) (2006)

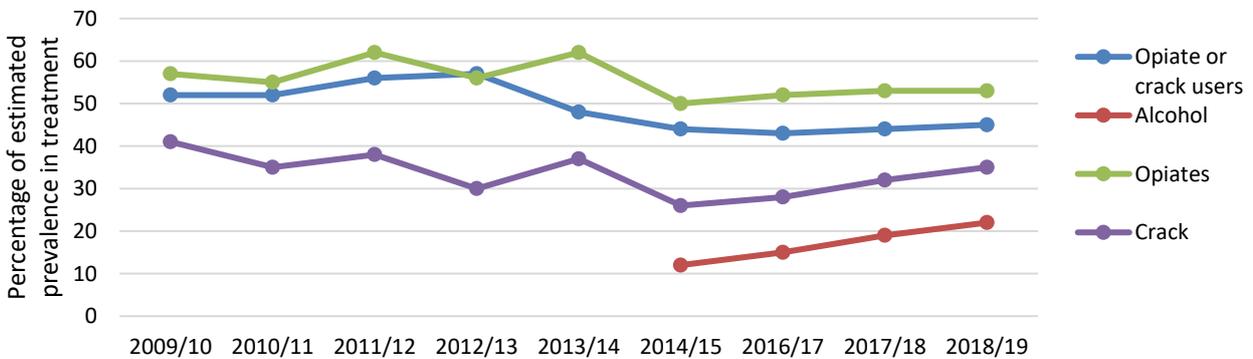
6.5 Meeting estimated need for alcohol and drug users

Based on figures of estimated prevalence in the population (section 4.2 above) it is possible to calculate an estimate of unmet need in the community, based on those known to be in services. It is worth repeating that confidence intervals for local authority estimates are wide and therefore point-estimates are used to indicate generalisations, rather than provide sure values.

- As we know that 1,135 individuals were receiving opiate services in 2016/17 and the confidence estimates for opiate prevalence were between 1,200 and 3,100, it is possible that most of the population was being supported, however prevalence in the population is unlikely to rest at the lowest margin. This suggests that many more individuals (some hundreds to over a thousand) were and are currently unsupported. For alcohol, 800 individuals were receiving support in 2016/17 compared to an estimated prevalence of between 5,543 and 9,296. Even at the lowest estimates, this implies that services could be expanded widely to meet the needs in the community.

According to NDTMS point estimates, roughly half of opiate users in the West Sussex are not currently engaged in treatment, roughly a two-thirds of crack users, and roughly three quarters of those with alcohol dependencies. Alcohol service users have expanded in numbers since 2014, when this was added to the datasets by NDTMS. Unmet need for prescription-only medicines (POM) or over-the-counter medicines (OTC) is not known, but these are a factor in approximately 15% of treatment activity (see Section 6.3.4)

Figure 6.11, Those in treatment as a percentage of estimated prevalence in West Sussex



Source: NDTMS

6.6 Referral routes into treatment and waiting times

Understanding referral pathways into treatment gives an indication of the level of referrals from various settings into specialist treatment. The Criminal Justice System refers to those referred through an arrest referral scheme, via an Alcohol Treatment Requirement (ATR), prison or the probation service. Referrals from health and social care also include referrals from alcohol care teams and people identified as potentially dependent through the alcohol and tobacco CQUIN. Self-referrals, or those made by family or friends carry hidden issues, as a relative reduction of

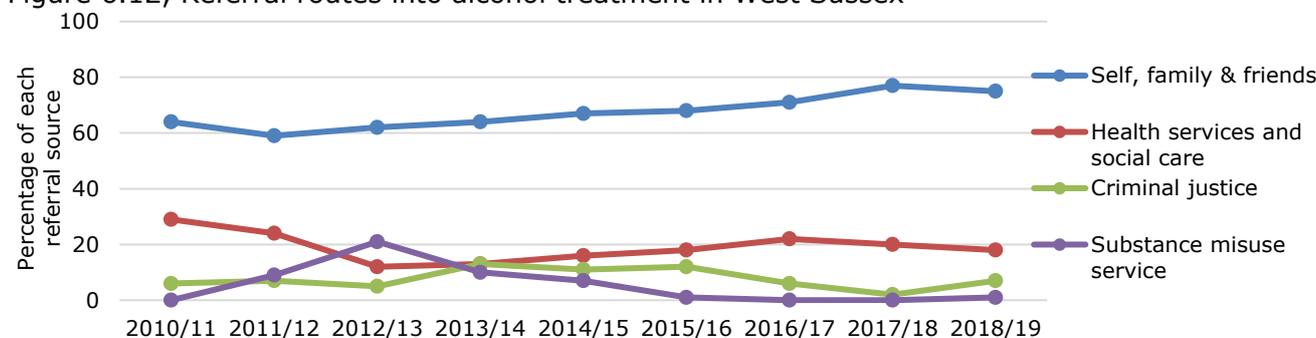
more formal pathways increases possible issues around equity of access; barriers specific to social or cultural groups may be hidden in the overall increase in informal referral pathways.

6.6.1 Alcohol referrals

During the past decade the proportion of referrals into alcohol treatment from informal sources (self, family or friends) has increased in West Sussex, from 60% to roughly 75%. These match national rates, though 4% of national referrals in 2018/19 came from 'other' sources and 3% from substance misuse services, leaving only 66% using informal or self-referrals.

Variation in referral sources between authorities may be due to differences in commissioned services and choices being made. Nationally, criminal justice referrals have been decreasing over the past decade, from 5,000 a year to 3,000 a year. West Sussex values have fluctuated between 20 and 50 a year without a clear decreasing trend.

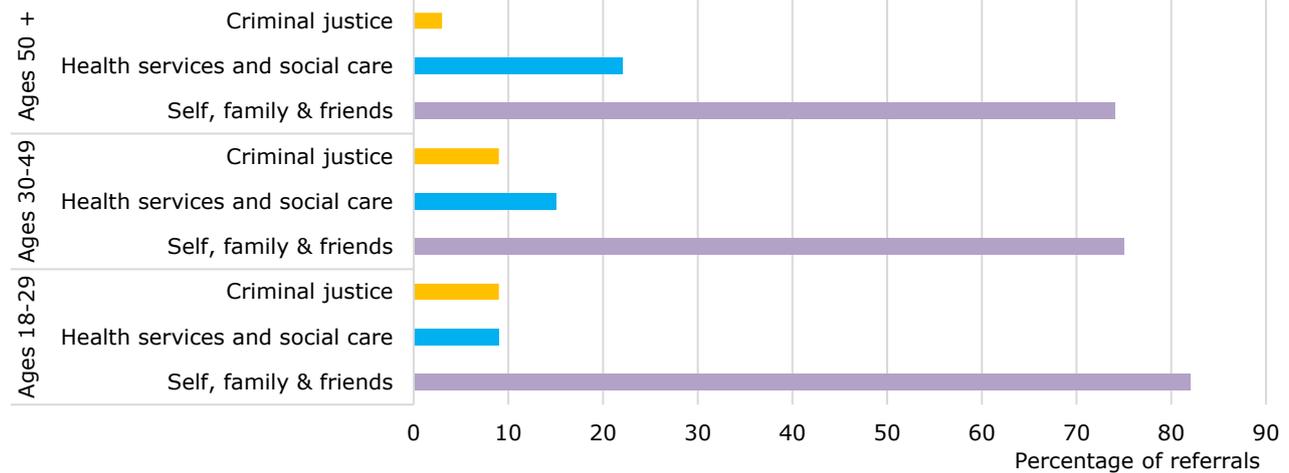
Figure 6.12, Referral routes into alcohol treatment in West Sussex



Source: NDTMS

Whilst informal referral sources are consistently more common, those in younger age bands have a higher rate of referral than others from the criminal justice system (9%), whereas those in older age bands have a higher rate of referrals than others from health and social care (22%).

Figure 6.13, Most common alcohol service referrals in West Sussex, by age band (2018/19)

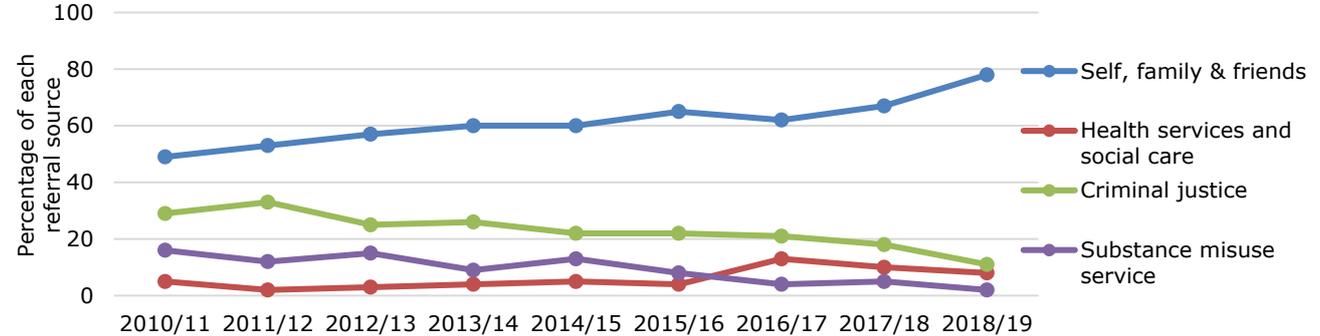


Source: NDTMS

6.6.2 Opiates

During the past decade the proportion of referrals into opiate treatment from informal sources (self, family or friends) has increased in West Sussex, from roughly 50% to near 80%. As with alcohol referrals, those from criminal justice sources have decreased over ten years, both locally (from around 100 to 35 a year) and nationally (from 17,000 to 10,000 a year).

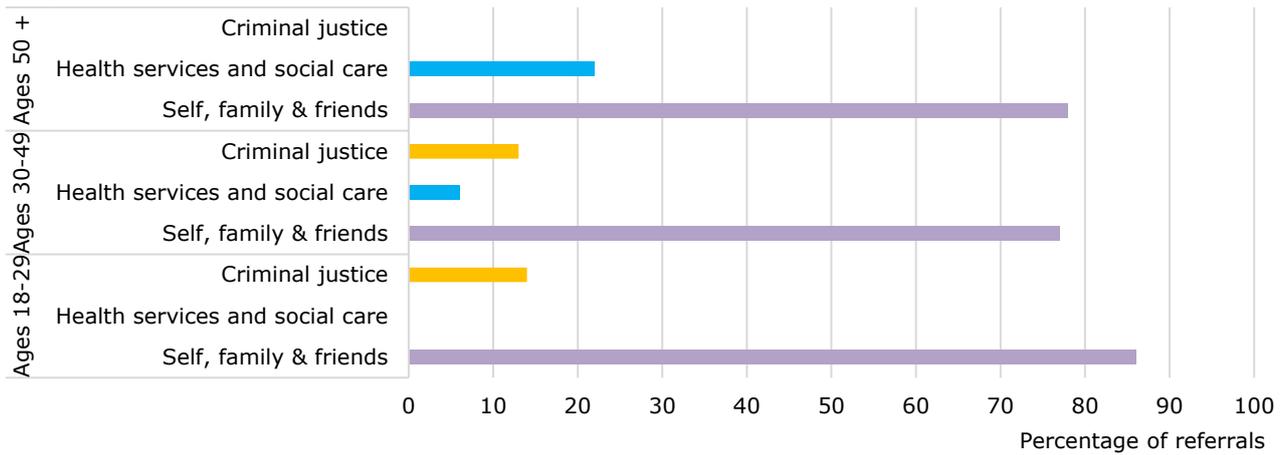
Figure 6.14, Referral routes into opiate treatment in West Sussex



Source: NDTMS

Whilst informal referral sources are consistently more common, those in younger age bands have a higher rate of referral than others from the criminal justice system (14%), whereas those in older age bands have a higher rate of referrals than others from health and social care (22%).

Figure 6.15, Most common opiate service referrals in West Sussex, by age band (2018/19)

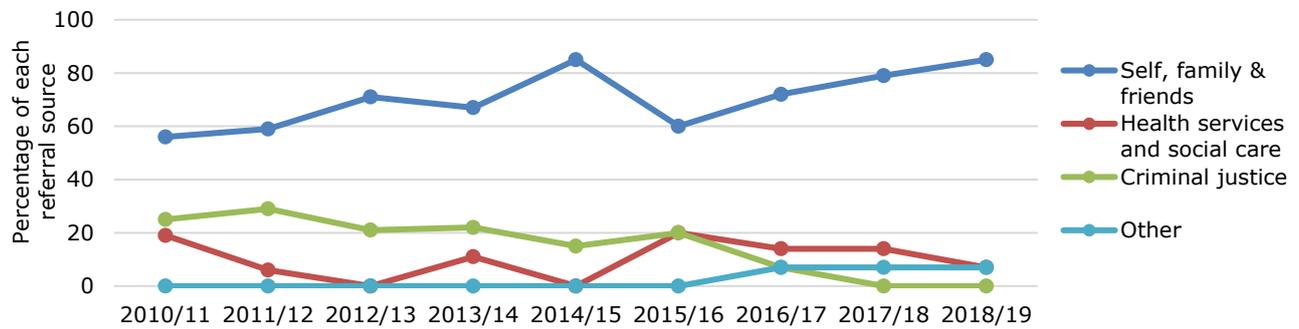


Source: NDTMS

6.6.2 Non-opiates

During the past decade the proportion of referrals into non-opiate (only) treatment from informal sources (self, family or friends) has increased in West Sussex, from roughly 60% to over 80%. Low numbers can make rates for this indicator more volatile and makes comparisons by age band impractical.

Figure 6.16, Referral routes into non-opiates treatment in West Sussex



Source: NDTMS

Locally there is a higher reliance on informal referral routes (85%) than from other organisations, when compared to regional (78%) and national (66%) averages. This pattern has remained consistent in recent years.

Table 6.5, Referral sources for non-opiates compared with regional and national benchmarks

Referral Source	Area	2016/17 (%)	2017/18 (%)	2018/19 (%)
Self, family & friends	England	57	61	66
Health services and social care	England	17	17	15
Criminal justice	England	15	13	10
Substance misuse service	England	3	3	2
Other	England	8	6	7
Self, family & friends	South East	74	72	78
Health services and social care	South East	9	11	11
Criminal justice	South East	7	7	7
Substance misuse service	South East	5	6	1
Other	South East	6	5	4
Self, family & friends	West Sussex	72	79	85
Health services and social care	West Sussex	14	14	7
Criminal justice	West Sussex	7	0	0
Substance misuse service	West Sussex	0	0	0
Other	West Sussex	7	7	7

Source: NDTMS

6.6.4 Waiting times

People who need alcohol treatment need prompt help if they are to recover from dependence and keeping waiting times short can play a vital role in supporting recovery from alcohol dependence. In the past several years, at least 98% of alcohol service users have started their first treatment intervention within three weeks after being referred to treatment; 100% of opiate service users and non-opiate service users have also started their treatment within three weeks of their first referral, as have co-occurring alcohol and non-opiate service users. These are in line with or exceed national benchmarks.

6.7 Treatment settings

The types of intervention delivered to service users will have an impact on their achievement of recovery outcomes. The tables below shows what interventions are delivered locally and in what setting. For alcohol treatments, 98% of support occurred in the community. The majority of alcohol support is psychosocial in nature, with recovery support in the community. Pharmacological support was used by 113 individuals in 2019/20, mainly in the community.

Table 6.6, Treatment settings for those engaged with alcohol treatments in West Sussex

Setting	Pharmacological		Psychosocial		Recovery Support		All individuals*	
	Count	%	Count	%	Count	%	Count	%
Community	91	81%	977	98%	935	99%	981	98%
Inpatient unit	4	4%	4	0%	4	0%	4	1%
Primary care	14	12%	4	0%	3	0%	20	2%
Residential	6	5%	41	5%	11	1%	41	4%
Recovery house	0	0%	0	0%	0	0%	0	0%
Young person setting	0	0%	< 3	0%	0	0%	< 3	0%
All individuals*	113	-	998	-	940	-	1,000	-

*Totals are not sums of the counts in these settings, as individuals may use multiple services

Source: Source: PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

For drug treatment, nearly all service users had treatments in the community, regardless of treatment need and near all of these were psychosocial. Most required recovery support and about half also needed some form of pharmacological support.

Table 6.7, Treatment settings for those engaged with drug treatments in West Sussex

Setting	Pharmacological		Psychosocial		Recovery Support		All individuals*		by sex	
	Count	%	Count	%	Count	%	Count	%	Males	Females
Community	1,088	99%	1,900	99%	1,777	99%	1,908	99%	99%	98%
Inpatient unit	20	2%	16	1%	15	1%	21	1%	1%	2%
Primary care	29	3%	4	0%	8	0%	41	2%	2%	1%
Residential	16	1%	60	3%	20	1%	63	3%	3%	3%
Recovery house	0	0%	0	0%	2	0%	2	0%	0%	0%
Young person setting	0	0%	10	1%	5	0%	10	1%	0%	2%
All individuals*	1,101	-	1,927	-	1,729	-	1,946	-	-	-

*Totals are not sums of the counts in these settings, as individuals may use multiple services

Source: Source: PHE, West Sussex Adults – drugs commissioning support pack 2021-22: key data

6.7.1 Residential rehabilitation

Structured alcohol treatment mostly takes place in the community, near to users' families and support networks. However, in line with NICE recommendations, a stay in residential rehabilitation is appropriate for those with the most complex needs, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system. Residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment at any stage of their treatment, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.¹⁰⁶

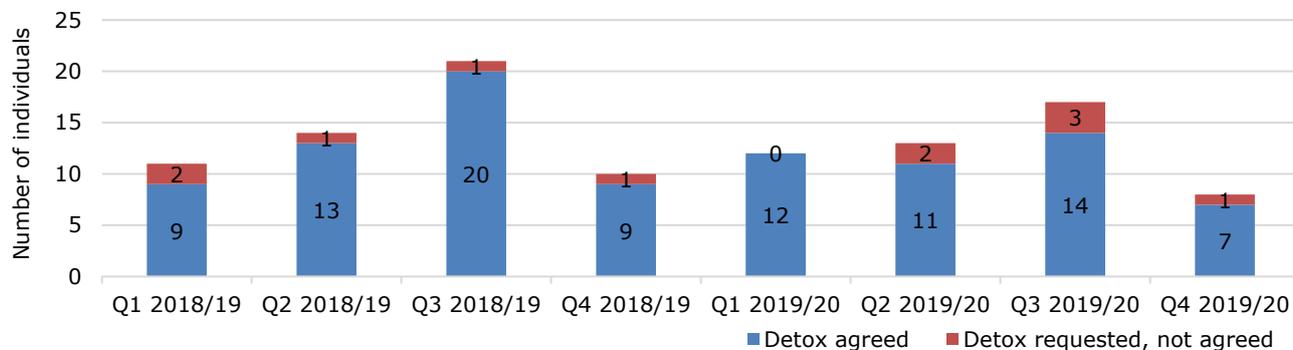
These are the number of adult service users in the local area who have been to residential rehabilitation during their latest period of treatment (as a proportion of the local treatment population and against the national proportion).

In West Sussex, 60 individuals were using residential rehabilitation for alcohol problems in 2018/19, 6% of service users, compared to 3% of national service users. A further 74 individuals

¹⁰⁶ Source: PHE, West Sussex Adults – drugs commissioning support pack 2021-22: key data

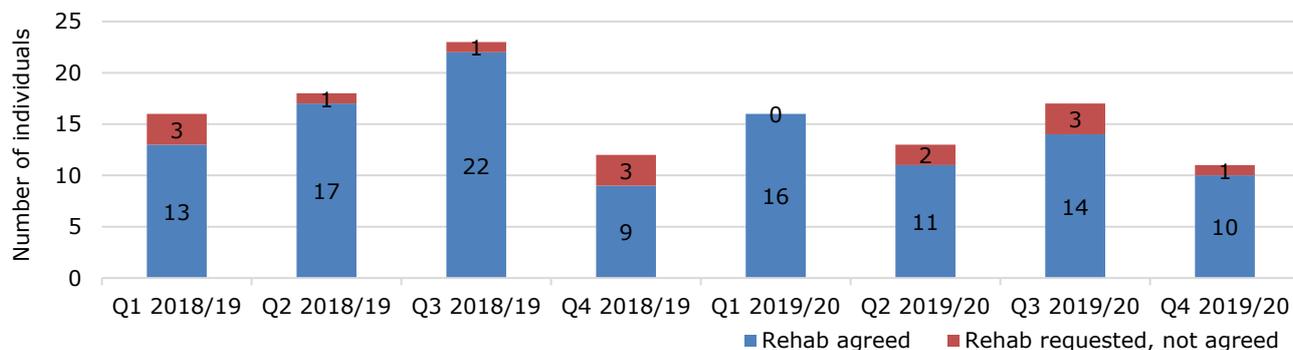
were using residential rehabilitation for drug problems, 4% of service users, compared to 2% nationally. Two thirds of these were males. Not all requests for residential treatment are accepted, but it is possible to view rolling monthly averages which indicate that demand tends to be higher in the winter months and lower in summer months.

Figure 6.17a, Detoxification places requested and agreed in West Sussex



Source: West Sussex County Council performance figures, (quarterly)

Figure 6.17b, Rehabilitation places requested and agreed in West Sussex



Source: West Sussex County Council performance figures, (quarterly)

Pooling the data together for the year, we can see the outcomes for rehabilitation and detoxification placements, all of which are aged over 18 years. These are grouped by following criteria:

- Lot 1 - Inpatient Detoxification Services for all ages
- Lot 2 - Inpatient Detoxification Services combined with Residential Rehabilitation Services for YP and Adults
- Lot 3 - Residential Rehabilitation Services for Adults
- Lot 4 - Residential Rehabilitation Services for Young People (18-24 years)¹⁰⁷

¹⁰⁷ There were no occurrences of Lot 4 criteria in West Sussex for the years 2018-2020

Table 6.8, Percentage of those who completed their treatment in residential placements

Period	Lot	Alcohol	Drugs	Both	All placements
2018/19	1	62%	0%	50%	56%
	2	84%	83%	NA	84%
	3	59%	50%	0%	55%
2018/19 total		69%	64%	33%	67%
2019/20	1	75%	100%	100%	82%
	2	81%	65%	100%	78%
	3	55%	75%	67%	61%
2019/20 Total		76%	68%	89%	76%
Total placements (count)		(121)	(12)	(33)	(166)

Source: Internal WSCC performance data

6.8 Length of treatment and retention

NICE Clinical Guideline CG115 recommends harmful and mildly dependent drinkers receive a treatment intervention lasting three months, those with moderate and severe dependence should receive treatment for a minimum of six months while those with higher or complex needs may need longer in specialist treatment. Retaining clients for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.¹⁰⁸

In West Sussex, the average time spent in alcohol treatment before successful exit in 2019/20 was 183 days (down from 220 days the previous year), compared to 180 nationally. Roughly 67% of service users completed treatment within six months (an increase from 58% the previous year), compared to 68% nationally.

Table 6.9, Length of alcohol treatment for those in treatment (2019/20)

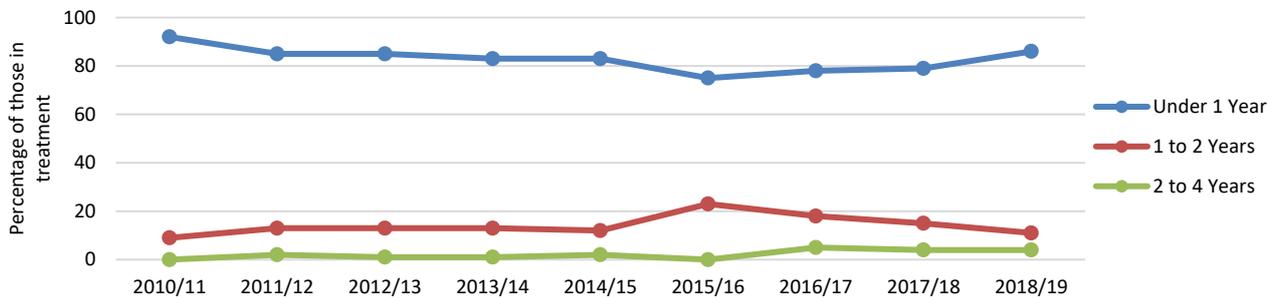
Length of treatment	West Sussex		National	
	Count	% of all exits	Count	% of all exits
< 1 month	26	4%	4,267	9%
1 to <3 months	155	25%	12,814	27%
3 to <6 months	233	38%	15,107	32%
6 to <9 months	105	17%	6,981	15%
9 to <12 months	47	8%	3,482	7%
12 months and over	50	8%	5,030	11%
(Average days in treatment)	(183)	-	(180)	-

Source: Source: PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

¹⁰⁸ Source: Extract from PHE, West Sussex Adults – alcohol commissioning support pack 2021-22: key data

In recent years, the average length of time in which people are receiving alcohol treatment in West Sussex has decreased and the percentage of those spending more than a year in treatment has returned to pre-2015 levels.

Figure 6.18, Length of time people have been in alcohol treatment in West Sussex



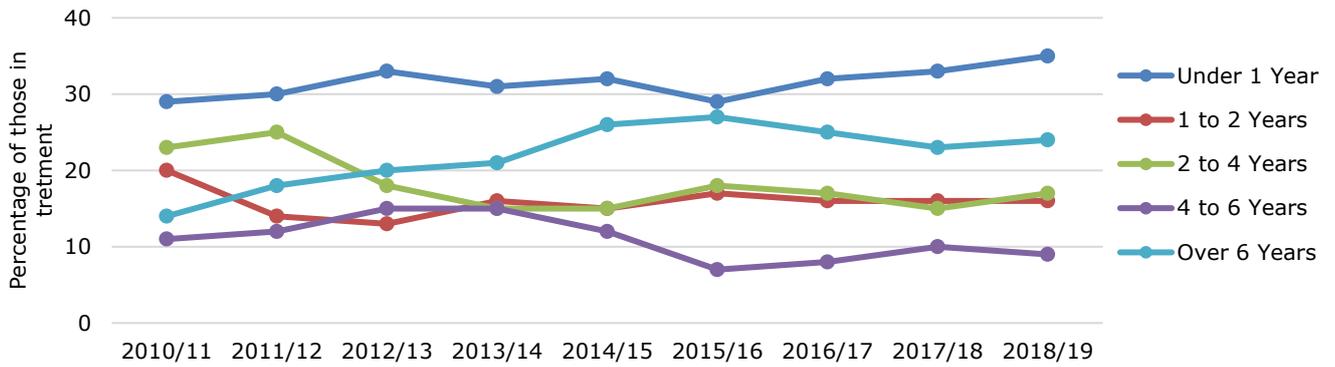
Source: NDTMS

Clients that have been in treatment for long periods of time (six years or over for opiate clients and over two years for non-opiate clients) will usually find it harder to successfully complete treatment. Current evidence shows that opiate clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery.¹⁰⁹

In West Sussex, 35% of those receiving opiate treatment in 2018/19 had been using services for less than a year. However, 24% were receiving treatment for more than six years. These figures are broadly in line with national and regional averages.

Figure 6.19a, Length of time people have been in opiate treatment in West Sussex (Percentage)

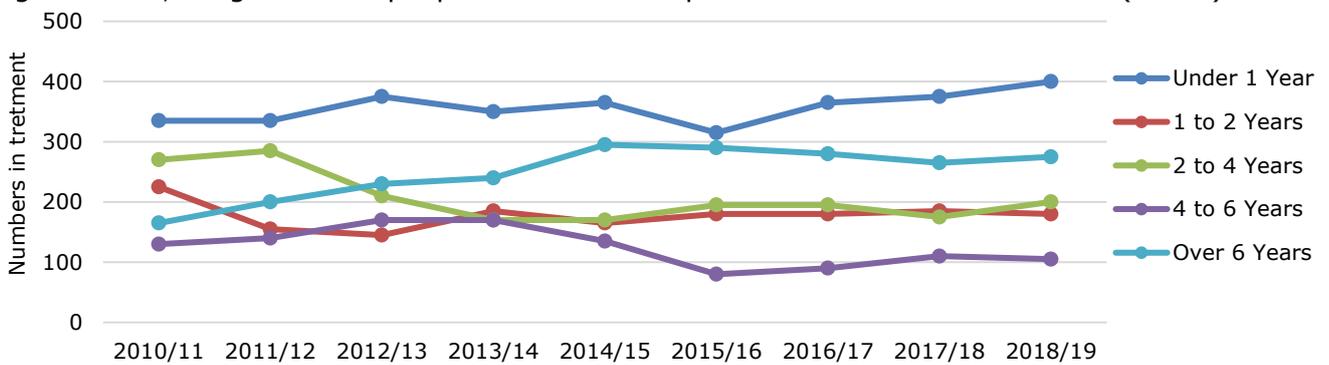
¹⁰⁹ Source: NDTMS data summary



Source: NDTMS

Relative percentages can mask trends in the numbers or scale, however and viewing the numbers of individuals we can see that individuals in long-term treatment have increased over the past decade, from 165 to 275 each year. Similarly, those in treatment for under a year have increased from 335 to 400 each year, whilst other groups have decreased.

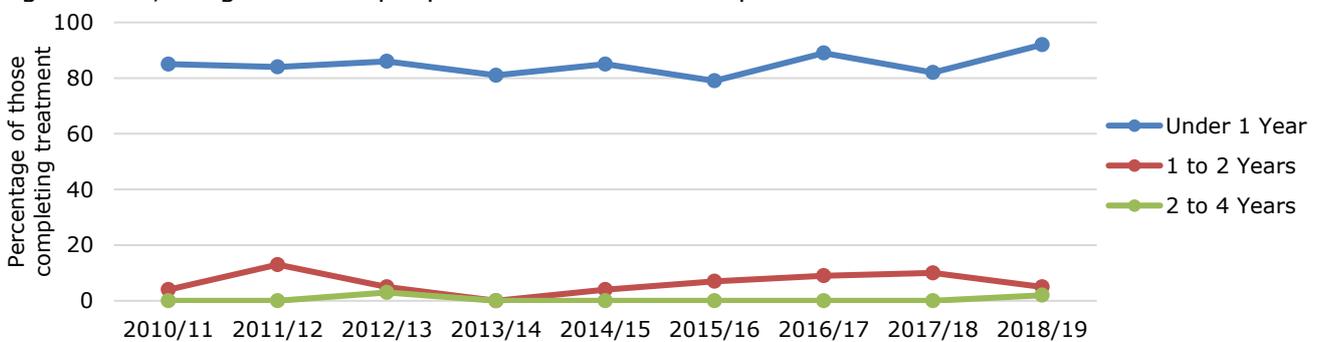
Figure 6.19b, Length of time people have been in opiate treatment in West Sussex (Count)



Source: NDTMS

For non-opiate service users, 92% of those in treatment had been so for less than a year, and no treatment lasted more than four years. Like alcohol service users, these figures are broadly in line with regional and national averages.

Figure 6.20, Length of time people have been in non-opiate treatment in West Sussex



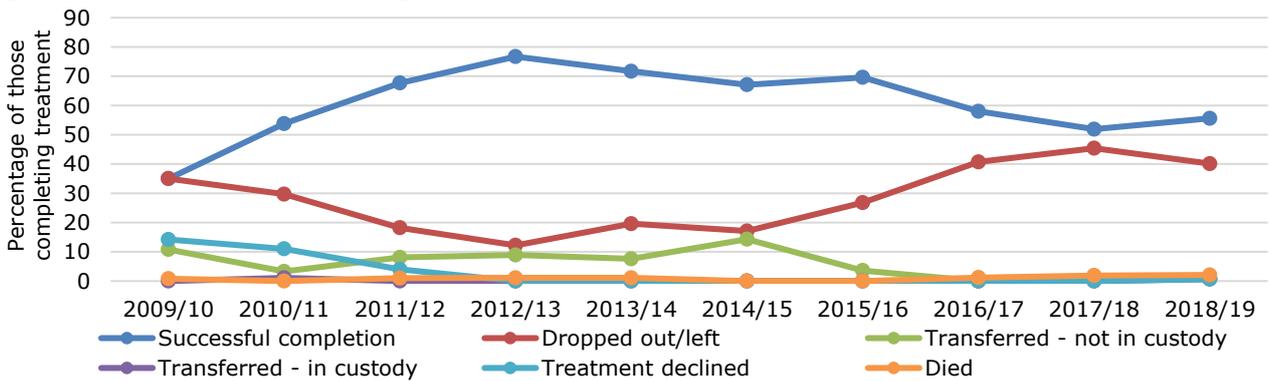
Source: NDTMS

6.9 Successful and unsuccessful treatments

6.9.1 Reasons for service exit

The following data show all those who exited treatment, by the type of exit. Successful treatments for alcohol problems have fallen in recent years from a high of over 70% to roughly 55%. Rates of those dropping out have increased from around 15% to over 40%. Nationally and regionally, successful completions have been steady at around 60% for a number of years.

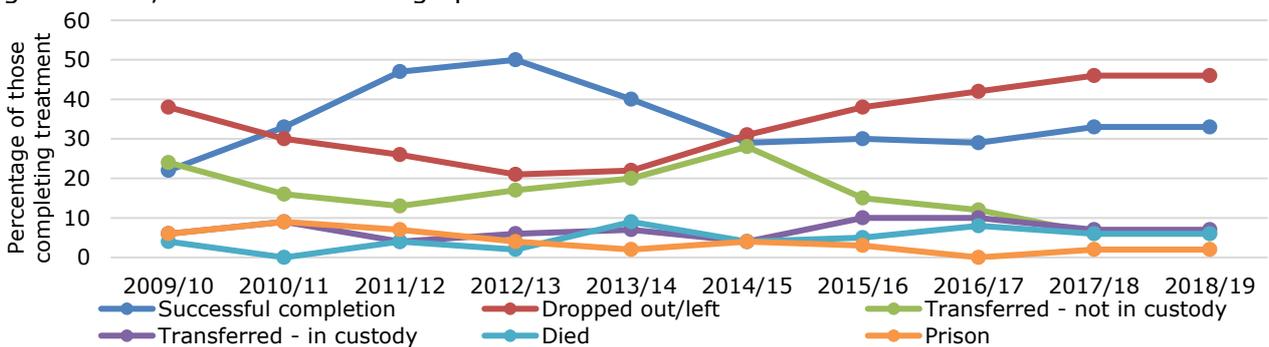
Figure 6.21, Reasons for exiting alcohol treatment in West Sussex



Source: NDTMS

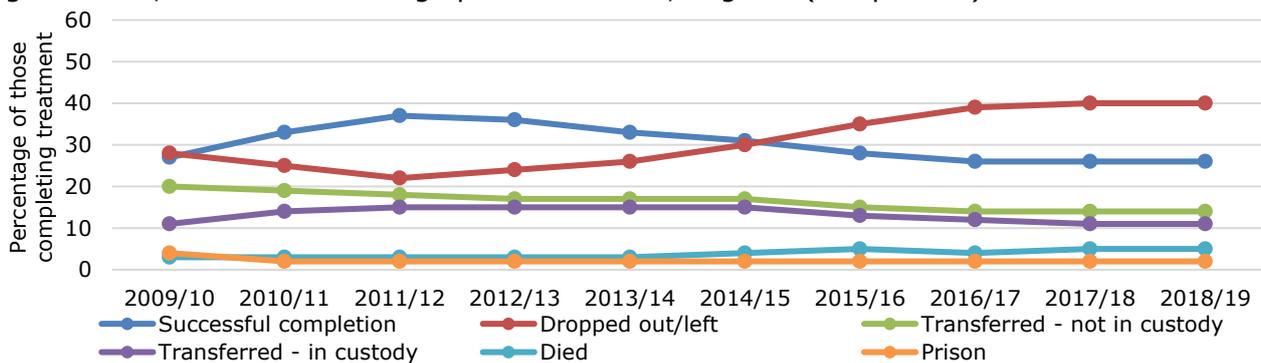
Over the past few years in West Sussex, approximately 7% of those receiving opiate support died whilst in treatment. This is slightly higher than regional (4%) and national (5%) averages. Around 2014, the rates of drop-outs in West Sussex increased from around 20% to 45%, whilst successful completions fell from 2012 highs of 50% to a steady 30-35%. Nationally, successful treatments for opiates have fallen from 35% to 25% in recent years and drop-outs have risen from around 25% to 40%. The shape of these trends match those of West Sussex.

Figure 6.22a, Reasons for exiting opiate treatment in West Sussex



Source: NDTMS

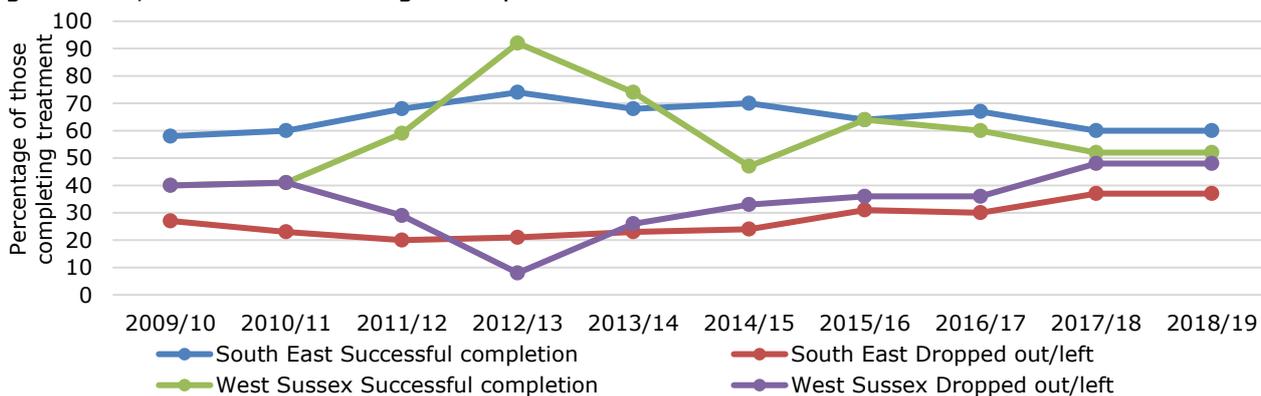
Figure 6.22b, Reasons for exiting opiate treatment, England (comparator)



Source: NDTMS

For non-opiates, West Sussex has a consistently higher rate of drop-outs than regional averages. In recent years, half of service users complete their treatment and half leave before the end of treatment (60% and 37% regionally, respectively). These rates hold true for those receiving support for alcohol and non-opiates at the same time.

Figure 6.23, Reasons for exiting non-opiate treatment in West Sussex

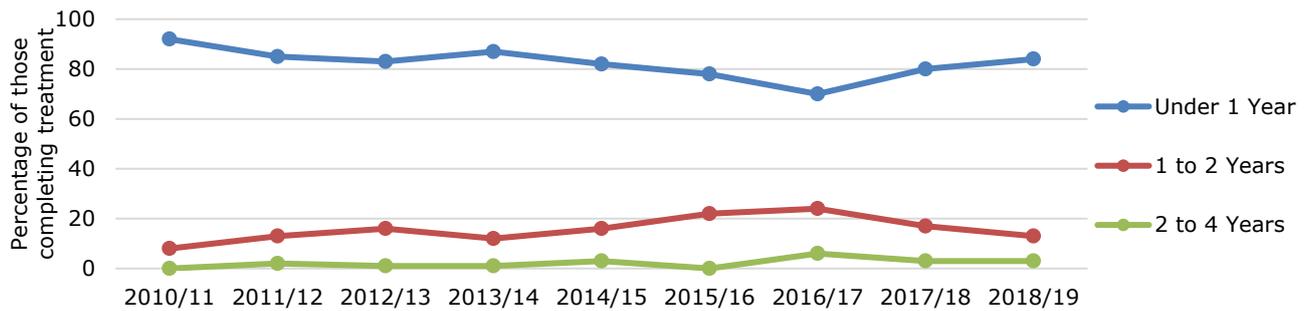


Source: NDTMS

6.9.2 Length of treatment for service leavers

People are defined as 'continually being in treatment' if the time between two contacts with treatment services is no longer than 21 days; this can include planned exits and unplanned exits. Over 80% of those in alcohol services leave treatment within a year. This is higher for younger service users. Females have a higher proportion of service users spending more than a year in treatment (roughly 20-25% with annual fluctuations) than males (15-20%).

Figure 6.24, Time spent in alcohol treatment in West Sussex for those exiting each year

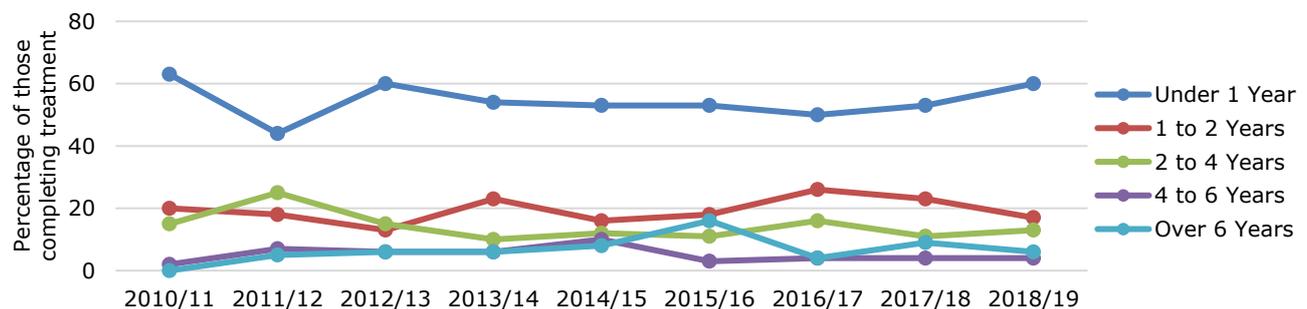


Source: NDTMS

Opiate treatments tend to take longer, with only 50-60% exiting services within a year. Consistently a quarter of opiate service users are in treatment for over two years. Whilst numbers are small, female opiate users tend to leave services sooner than males. Over the past five years, approximately 50% of males exit services within a year, compared to 63% of females. Data are not readily available to know if this is due to dropouts or to successful treatments and this pattern is not seen nationally, where males and females have similar service lengths. Successful treatments for males are approximately the same in West Sussex compared to nationally, though West Sussex females have a higher rate (40-50%) of successful treatments compared to nationally (30-40%).

Whilst local numbers fluctuate from year to year, nationally more younger service users leave services within a year than older service users (75%, 60% and 40%, for 18-29s, 30-49s and over 50s respectively). As successful treatments by age band are consistent over the years, it is likely that the higher turnover of younger services is not a result of unsuccessful treatments, but of a faster movement through the process, be it resulting in successful treatment or otherwise.

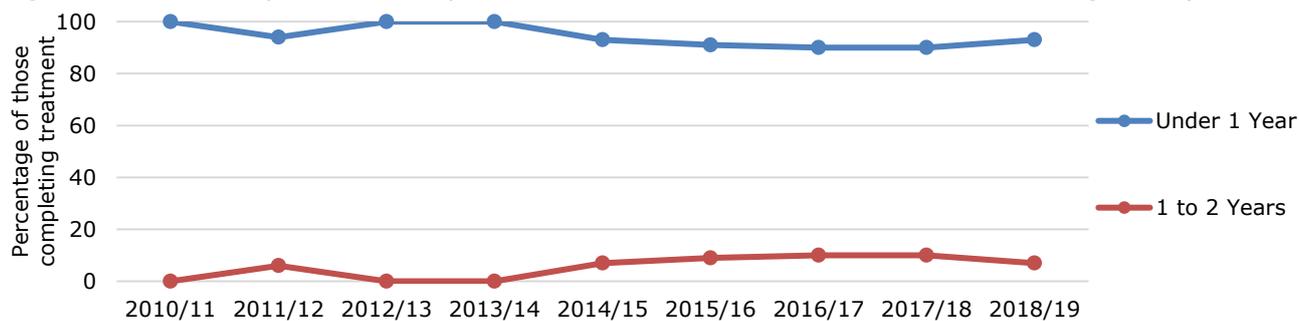
Figure 6.25, Time spent in opiate treatment in West Sussex for those exiting each year



Source: NDTMS

Similar to alcohol services, those receiving treatment for non-opiate drugs tend to spend less than a year with services (at least 90%). This is roughly equivalent for males and females, across age groups and in line with national averages.

Figure 6.26, Time spent in non-opiate treatment in West Sussex for those exiting each year



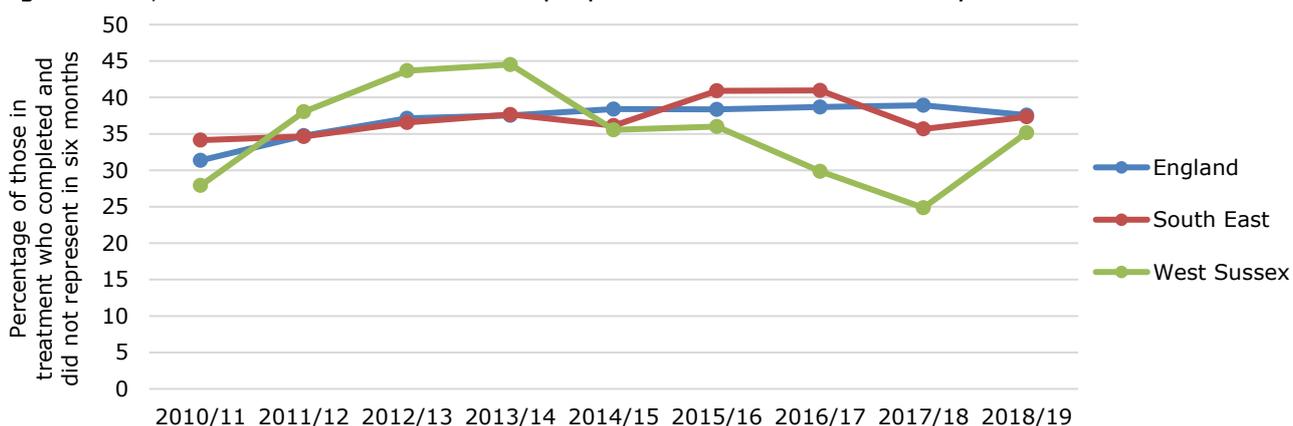
Source: NDTMS

6.9.3 Successful treatments without re-presentation

Public Health Outcomes use the benchmark of successful treatment programmes as completing treatment and not representing for at least six months (to any service in the nation). Data is presented as the proportion of all those in treatment for a given year and so percentages are naturally low.

Of the 1,095 individuals receiving alcohol treatment in West Sussex in 2018/19, 35% completed their treatment and did not represent to the service within six months. These rates were roughly in line with regional (37%) and national rates (38%) and were similar for males and females. In recent years however, West Sussex rates of successful treatment have been lower than the South East And national benchmarks. Locally there is some variation between age bands likely due to smaller numbers, but nationally and regionally there is little difference between successful outcomes in alcohol treatment for different age bands.

Figure 6.27, Successful treatments as a proportion of all those currently in alcohol treatment

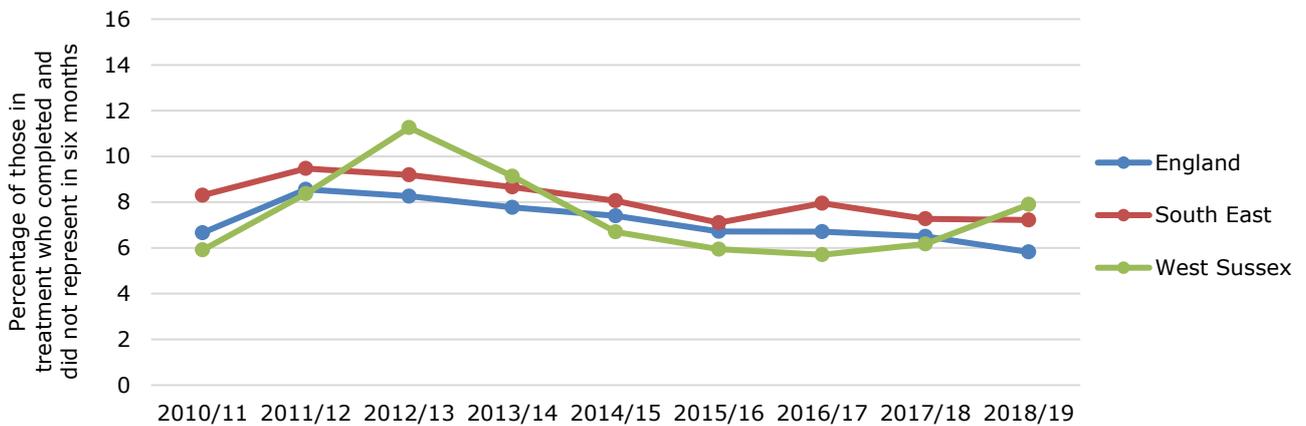


Source: NDTMS

Of the 1,140 individuals receiving opiate treatment in 2018/19, 8% were able to complete treatment and not return to services within six months. This upturn is higher than regional (7%) and national (6%) benchmarks, and provisional data suggests that recently West Sussex have been improving these outcomes, reversing a general downward trend seen elsewhere in recent

years. These figures are largely similar for males and females, though locally females maintain slightly higher percentages here. Despite small numbers, those in the mid-age bracket (aged 30-49) tend to show lower successful treatments than younger or older age bands. In the past three years, successful treatment outcomes for opiate services were 8%, 6% and 8% for 18-29s, 30-49s and over 50s respectively.

Figure 6.28, Successful treatments as a proportion of all those currently in opiate treatment

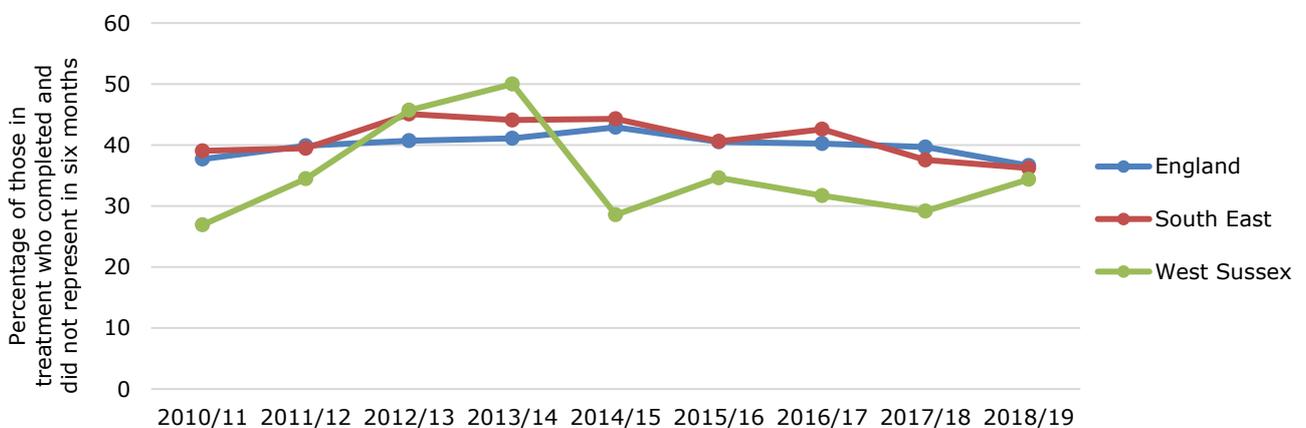


Source: NDTMS

Successful completion for non-opiates are also lower in West Sussex compared with England and the regional picture. However, in the most recent year of data (2018/19) there has been an increase in successful completion in West Sussex, whereas the South East and England rate has fallen.

West Sussex successful treatments in a given year tend to rest around 30-35% in recent years, whilst regional and national averages have dropped from 45% to 35% over the same period. There does not appear to be any significant difference between males and females, or in different age bands, locally or nationally.

Figure 6.29, Successful treatments as a proportion of all those currently in non-opiate treatment



Source: NDTMS

Alcohol and Drug Treatment Service Users, Key Summary:

Public Health England estimates that alcohol treatment yields a return on investment of £3 for every £1 invested, which can increase to £26 over 10 years. Drug treatment provides a return on investment of £4 for every £1 invested, which can increase to £21 over 10 years. Treatment can be enacted and expanded through a range of evidence-based mechanisms. Due to wide estimates of prevalence, it is difficult to estimate the scale of unmet need; estimates of the number of residents with unmet needs range from hundreds to thousands.

Alcohol treatment service use in West Sussex has increased in recent years, from roughly 650 to 1,100 residents per year (roughly 60% males; 40% females). Roughly 40% of these were in regular employment at start of treatment and 13% had housing problems. This highlights the considerable social and economic challenges people with substance misuses problem can face and the range of issues which services need to support people to overcome.

Opiate service use in West Sussex has remained relatively stable, around 1,150 residents each year, but numbers of non-opiate service users have doubled, from about 150 to 300 residents each year (roughly 70% males; 30% females). Regular employment (31% at start of treatment) may be an indicator for a higher likelihood of completing opiate treatment. A recognised housing problem was recorded for one in three opiate service users.

In 2017, 17% of the national population used antidepressants and 13% used opiate pain medications. The Faculty of Pain Medicine estimate that 8-12% of long term prescribed opioid users would currently, or in the past, meet the criteria for an opioid use disorder. In West Sussex, there were 85 residents in treatment for prescription-only medicines (POM) or over-the-counter medicines (OTC).

In line with national guidance, over 95% of opiate service users have been supplied with naloxone by June 2020. Services have provided 500-900 residents a month with needles, syringes and other equipment used to prepare and take drugs.

Informal referral pathways for alcohol and drug services (i.e. self-referral, or by friends and family) have increased in the past decade from roughly half to nearly four in every five. It is likely that this relative change is driven by both a decline in formal pathway referrals (i.e. criminal justice, or health services), and by expanded awareness in the community. Nearly all service users were recorded as starting treatment within three weeks of their referral.

Nearly all of alcohol and drug treatment occurs in community settings, but from 2018-20 there were 103 residential placements for detox and rehab treatments in West Sussex; 76% of service users completed their treatment.

Alcohol and Drug Treatment Service Users, Key Summary (continued):

Two thirds of successful alcohol treatments last under six months, but 8% last more than a year. Opiate treatments are most effective when completed within two years, but one in four service users in West Sussex have been in treatment for more than six years (in line with the national average). Decisions over how long an individual should remain in treatment often comes down to personal circumstances and safeguarding concerns.

Successful completions of treatment for alcohol services have fallen from highs of over 70% in 2014 to roughly 55% in 2019, with drop-out rates in the same period increasing from 15% to over 40%. In the same time, roughly 7% of those receiving opiate support died (from any cause) whilst in treatment and drop-outs in West Sussex increased from around 20% to 45%. These are comparable with the national picture.

Public Health England benchmark the performance of treatment services by whether people complete treatment and do not represent to treatment within six months of completion. Of those receiving alcohol treatment in 2018/19, 35% completed their treatment and did not represent to the service within six months. Of those receiving opiate treatment and non-opiate treatment in 2018/19, 8% and 35% (respectively) were able to complete treatment and not return to services within six months.

There is local outreach support, but levels of provision may be worth further exploration and review, in line with PHE recommended mechanisms for improving access and retention for services. For example, factors associated with increased service retention include being in education or employment, being in good physical health, and not drinking alcohol every day. Factors decreasing the likelihood of successful treatment include having housing problems, living in an area of higher deprivation, previously dropping out of treatment. Other outreach can include needle and syringe programmes, open sessions and sessions restricted to particular groups and issues, providing transport and childcare, and ensuring effective and supported pathways to treatment from prison.

Changes in the service specifications in 2016/17 may explain the fluctuations in some performance and service indicators, as a function of supply-led service demand. This includes an expansion of services (particularly alcohol services) and may explain the increase the informal referrals, which in turn may affect the successful outcomes or length in treatment. Closer examination may be required to the contexts and mechanisms behind outcomes seen.

Further exploration is warranted to find out why local and national drop-outs and successful completions (particularly for opiate treatment) shifted after 2012. This may be for example, due to changes in pathways, with an increase in self-referrals, or due to a change in wider approaches.

7. Mental Health and Pathways for Co-Existing Conditions

This section summarises the national policy and guidance, and the local evidence relating to the joint issues of co-occurring substance misuse and mental health problems, and then outlines a number of gaps in our current knowledge which would be beneficial to fill in the near future. Some of this information is contained elsewhere in the needs assessment but is summarised here for clarity.

Key headings:

- 7.1 National recommendations for co-occurring conditions
- 7.2 Coexisting mental health and substance misuse conditions in West Sussex
- 7.3 Investment for the future

National policy and guidance clearly outline the need to address co-existing mental health and substance misuse problems and these combined are more complex than the existence of two separate issues. There are several possible pathways to explain the co-morbidity between substance misuse disorders and mental health conditions and these include:

- A substance use disorder and mental health condition can exist as independent conditions and their occurrence either due to chance or to a person having the same underlying risk factors.
- Mental health conditions can be a risk factor for substance misuse, this can be via the 'self-medication hypothesis' whereby an individual uses a substance to deal with symptoms arising from the mental health condition. The outcome of this can vary and for some people a substance use disorder may continue independently even after a mental health condition is addressed.
- Substance use can trigger development of an underlying mental health condition for example cannabis use and psychosis.
- A temporary mental health condition can result from substance use during intoxication or withdrawal from a specific substance.¹¹⁰

¹¹⁰ Source: EMCDDA, [Perspectives on drugs: Comorbidity of substance use and mental health disorders in Europe](#) (2016)

7.1 National recommendations for co-occurring conditions

In 2017, Public Health England published 'Better care for people with co-occurring mental health and alcohol/drug use conditions' to support local area commissioning for people with co-occurring conditions.¹¹¹ It also aimed to support the implementation of the five year forward view for mental health. The majority of people in community substance treatment experience mental health problems (including a high prevalence of co-occurring conditions among those who come into contact with the criminal justice system). They also have a heightened risk of other health problems and early death (the higher prevalence of smoking contributes to this increased morbidity). Individuals were shown to frequently be excluded from services including when intoxicated and experiencing mental health crises.

The report highlighted two key principles supporting the aims:

1. Everyone's job: that those commissioning and providing both mental health services and substance use services have joint responsibility.
2. No wrong door: all services should have an open door policy to ensure every contact counts and treatment is available through every contact point.

To support these, a number of priorities were proposed:

- agreeing a care pathway that delivers collaborative care (ensuring access to other services such as homelessness, domestic abuse and physical healthcare is enabled),
- ensuring every individual is assigned a named care coordinator,
- undertaking joint commissioning, enabling people to access the care they need, when needed in the most suitable setting,
- commissioning a '24 hour, 7 days a week' response to those experiencing mental health crisis, even when intoxicated,
- and ensuring individuals are helped to access a range of recovery support.

NICE have published quality standards covering the 'assessment, management and care provided for people aged 14 and over who have coexisting severe mental illness and substance misuse.'¹¹²

The four quality statements are:

1. 'Initial identification of coexisting substance misuse: people aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol drugs.'

¹¹¹ Source: PHE, [Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers](#) (2017)

¹¹²Source: NIHC, [Coexisting severe mental illness and substance misuse \(QS188\)](#) (2019)

2. 'Exclusion from services: People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness.'
3. 'Care coordinators: People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services.'
4. 'Follow-up after any missed appointment: People aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment.'

7.2 Coexisting mental health and substance misuse conditions in West Sussex

7.2.1 Individuals in receipt of drug and alcohol treatment

As outlined in Section 5.1, of new presentations to alcohol treatment in 2019/20, 365 (54%; 47% of males and 63% of females) were identified as having a mental health need. This is lower than the national average (55% of males and 66% of females) but has increased since the previous year. Of these, 24% of males and 27% of females were recorded as already engaged with the Community Mental Health Team or other mental health services (15% and 17% nationally); 53% of males and 56% of females were receiving mental health treatment from their GP (59% and 64% nationally). In all, 22% of males and 16% of females were not receiving treatment for their assessed mental health problems, which was roughly in line with national averages.

Of the adults who entered drug treatment in 2019/20, 540 (60%; 55% of males and 70% of females) were assessed as having a mental health treatment need (increasing from 53% the previous year). This was higher for non-opiate presentations compared to opiate presentations (68% to 53%). Of these individuals, 72% (68% of males and 79% of females) were already accessing mental health support services; 20% of males and 35% of females were already engaged with the Community Mental Health Team or other mental health services (17% and 21% nationally); and 48% of males and 43% of females were receiving mental health treatment from their GP (48% and 52% nationally). In all, 32% of males and 21% of females were not in receipt of treatment for their assessed mental health problems.

Table 7.1, Adults who entered drug treatment in 2019/20 and were identified as having a mental health treatment need

Treatment cohort	Number of new presentations	Proportion of all presentations	Proportion of male presentations	Proportion of female presentations
Opiates	171	53%	47%	65%
Non-opiates	158	68%	63%	78%
Non-opiates and alcohol	211	61%	57%	69%
All new drug presentations	540	60%	55%	70%

Source: PHE, West Sussex Adults - drugs commissioning support pack 2021-22: key data

7.2.2 Findings from the Rough Sleepers Needs Audit

From a recent audit in West Sussex (Summer 2020)¹¹³, there were an estimated 558 people who were homeless or rough sleeping and 58% of these were known to have a substance misuse need. Of these 558 people:

- Half (159 individuals) were known to Change Grown Live substance misuse treatment at the time of audit.
- Of the total population, 70% (391) were identified as having mental health problems and one in three of these were not receiving any support for these issues.
- Combined, 45% (249) of those included in the audit were identified as having poor mental health alongside substance misuse needs.
- Two thirds of those with coexisting conditions (158 individuals) were not accessing treatment or support for both their needs.
- Of those with coexisting conditions, 38% 95, individuals were also identified with physical health problems.

7.2.3 Drug misuse and mental health leading to death

The West Sussex 2019 drug misuse deaths audit identified a number of issues relating to mental health needs. Most notably, of the 123 residents to have died in the three-year sample, 66% (81 individuals) were known from records included in the coroner’s inquest files to have mental health needs. Whilst not all deaths were related to drug misuse (as defined by ONS), of the 65 cases classified as drug misuse deaths, 60% (39 individuals) were known to have mental health needs and 40% held prescriptions for psychoactive medication.

Table 7.2, The most common mental health needs for those included in the 2019 drug related deaths audit.

Mental health issues	All deaths		Drug misuse death		Other poisoning	
	Count	%	Count	%	Count	%
Depressive illness	66	54%	27	42%	39	67%
Anxiety/phobia/panic disorder/OCD	40	33%	22	34%	18	31%
Suicidal intent recorded	37	30%	15	23%	22	38%
Personality disorder	12	10%	8	12%	4	7%
Schizophrenia/similar disorders	8	7%	3	5%	5	9%

*Note, cases are not exclusive and some individuals had multiple illnesses; less common conditions were recorded but removed for this publication; ‘Other poisoning’ can include suicides and accidental poisonings with prescribed medicines. Source: PHSRU, West Sussex Drug Related Deaths 2015-2017 audit, 2019

The review also found that significant barriers to treatment can exist for those with co-existing conditions; particularly where some individuals were required to abstain from substance misuse

¹¹³ Source: WSCC, Key Findings from the Rough Sleepers Needs Audit, 2020

before beginning mental health treatment or required to engage with mental health treatment before being ready for substance misuse support.¹¹⁴

7.3 Investment for the future

Due to the issues identified previously in this report, a new local public health investment for managing coexisting mental health and substance misuse issues has been agreed as a strategic priority, in the form of staffing in community services. This funding is intended to embed principles of mental health support in substance misuse services and principles of substance misuse support in mental health services, from late 2020 onwards.

In order to maximise the impact of this new investment it is necessary to examine the local offer for addressing incidences of coexisting conditions in the community. This will require a focused approach to answer the following questions:

- What current service provision exists for those with coexisting conditions? What capacity and expertise exist within each service to support those with coexisting conditions?
- How do those with different levels of need for substance misuse issues (i.e. Prevention/early intervention, Structured treatment, and Pharmacological interventions) differ in their complexity of need in the context of mental health issues? i.e. Is there a linear or exponential increase in complexity or vulnerabilities?
- What barriers currently exist to successful access and to successful treatment outcomes for those with coexisting conditions?
- What is additional support required to reduce the risk of serious harm or death to those with coexisting conditions? This may include overdose, accidental death and suicide.
- How do professionals within services work on a day-to-day basis with people who have coexisting conditions? What issues do they face which may reduce their capacity to provide effective care and treatment?
- How do service users with coexisting conditions view the services they access? Are there barriers to access or issues of inequity?
- How can effective relationships be maintained between service users and treatment providers?
- What does an ideal system of support and treatment look like? Does this view differ from service to service, professional to professional, or from client to client?
- What would be beneficial, in terms of patronships and systems collaboration?

¹¹⁴ Source: West Sussex PHSRU, [West Sussex Drug Related Deaths](#) 2015-17 (2019)

Mental Health and Pathways for Co-Existing Conditions, Key Summary:

National policy and guidance clearly outline the need to address co-existing mental health and substance misuse problems and these combined are more complex than the existence of two separate issues. They have a heightened risk of other health problems and early death (a higher prevalence of smoking also contributes to this increased morbidity). Individuals with coexisting conditions are shown to frequently be excluded from mental health services when intoxicated and from substance misuse services when experiencing mental health crises.

PHE have published five priority recommendations to support these individuals, including: agreeing a care pathway that delivers collaborative care; ensuring every individual is assigned a named care coordinator; undertaking joint commissioning, enabling people to access the care they need; commissioning a '24 hour, 7 days a week' response to those experiencing mental health crisis, even when intoxicated; and ensuring individuals are helped to access a range of recovery support.

In West Sussex, over half of all those accessing alcohol or drug treatment services were identified as also having a mental health need. Of those with mental health needs, 19% of alcohol treatment service users and 28% of drug treatment services users were not accessing any support for known mental health problems.

Nearly half (45%) of all those identified in a West Sussex rough sleeping/homelessness audit in Summer 2020 were identified as having both mental health and substance misuse needs.

In a three-year period (2015-17), 66% of those who died from drug misuse or other drug poisonings in West Sussex were identified as having mental health needs (60% of those who died specifically from substance misuse). Depressive illnesses and anxiety-related illnesses were the most common issues for those who died. The audit found evidence of local barriers similar to those described in PHE's national review.

There is currently new local investment into drug and alcohol and mental health services to address issues of coexisting conditions, but there are currently gaps in our knowledge. To maximise the impact of this investment it is necessary to examine these issues more closely. This will require cooperation across partnerships to support effective outcomes.

8. COVID-19 Response and New Ways of Working

Due to the 2020 global outbreak of the disease Covid-19, in Spring 2020, providers of substance misuse prevention and treatment services have been developing new ways of working, particularly in the context of government mandated 'lockdowns' and a reduction of person-to-person contact in some, - but not all, - community settings. This section documents changes to service provision during 2020 and whilst learning and innovation is ongoing, it provides examples of service developments since then.

Key headings:

- 8.1. Service planning and the public health context
- 8.2 Effects of the lockdown on service outcomes
- 8.3 Lessons learned for the future

8.1. Service planning and the public health context

Service providers have been in consistent dialogue with commissioning leads and workstreams developed to estimate the effects on demand and delivery. The main programme activities have remained in place, i.e. Medication Assisted Treatment, Alcohol Offer, Harm Reduction activities, have remained in place.

Workforce Management and the Staffing/Health and Safety/Governance concerns included an agreed organisational response to ensure consistent Risk Assessments are in place; that all relevant guidance was followed to facilitate a planned return to the workplace and in line with existing PHE guidance; and includes consideration of sub-contractor required actions. There was no change at the time to the existing arrangements of skype/phone offers, with face to face appointments agreed on case by case basis.

Some major providers agreed to pause face-to-face meetings to assess new referrals, but online channels remained open.

8.1.1 Detox and Rehab provision

Referral rates remained low during the lockdown though this was monitored as lockdown measures were eased. The running concern was that there could be an increase in presentations, due to the lockdown itself, or as a backlog of people deferring presentation to services. Transition planning will need to include a focus on the availability of detox options (community and residential).

8.1.2 Naloxone

West Sussex programme leads worked with providers to review the delivery of overdose training & issue of Naloxone. It was requested that providers identify what additional sessions they could provide over the summer (of 2020) to front line workers supporting drug users placed as part of the Covid response.

8.1.3 Wellbeing hubs

All West Sussex wellbeing hubs were focused on smoking, alcohol and falls prevention; many continued to call clients directly, signposted to resources online, or developed their own online resources. Dedicated alcohol advisors where in post were reported to be holding steady and increasing caseloads of existing and new clients.

8.1.4 Alcohol early interventions

The DrinkCoach programme continued to deliver fully digital alcohol early intervention services, with no disruption and the Alcohol Wellbeing Advisors switched to delivering Extended Brief Interventions by telephone.

8.1.5 Service treatment outcomes

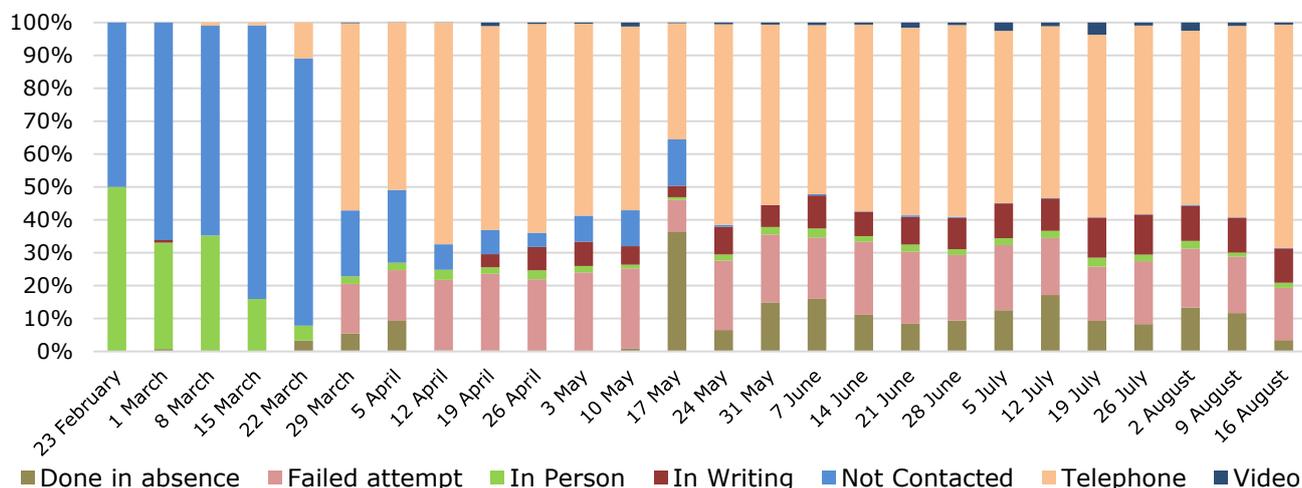
During the Covid-19 lockdowns in 2020, there was a reduction in "successful exits", (as seen on NDTMS data). Initial feedback from service leads and providers noted that keeping service users on record and in treatment was used as a protective factor for individuals in these uncertain times. This action was undertaken with knowledge and agreement of local commissioner.

8.2 Effects of the lockdown on service outcomes

As reviewed in Section 6, medically assisted treatments (MATs) for opiate addiction, can improve outcomes for service users and provide less health risk for individuals. Those receiving MATs are required to maintain regular contact with the service provider. During the lockdown months, one of the main service providers recorded a considerable change in both the methods of contact and an increase in the percentage of individuals maintaining regular contact. In February, as the pandemic was increasing, non-contacts increased and in-person contacts (the traditional method) decreased. The introduction of telephone contact methods in March showed a immediate drop in non-contacts, and 'failed attempts' were recorded for some individuals (where the impetus was on the provider to imitate the contact). Roughly 10% were regularly contacted in writing, but the use of telephone contacts replaced the need for the majority of face to face/in-person contacts.

A full review with service users would improve knowledge around the effectiveness of this method, but initial reports from the provider have indicated that service users were happy to engage with telephone check-ups and this also meant more regular contact was possible. The provider is currently reviewing their progress, but the model of telephone contacts may become more commonplace in future years.

Figure 8.1, Contact methods for those receiving Medically Assisted Treatments during lockdown



Source: CGL provider data (2020)

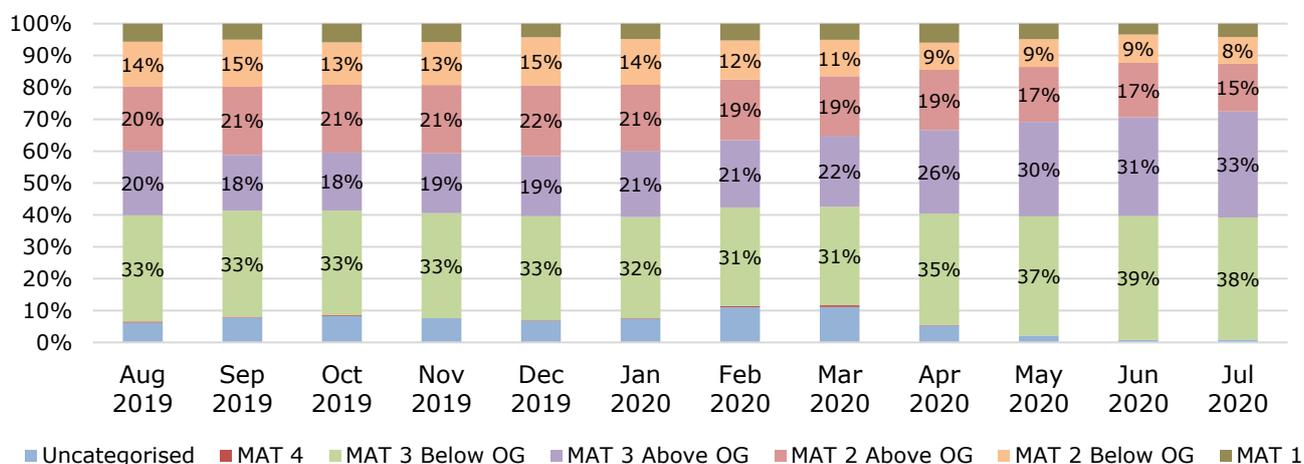
Medically assisted treatments (MATs) can be categorised into four main categories, along the following criteria:

- MAT 1 – Service users in the first 28 days of prescribing with a script whose previous prescription was more than five days, or no previous prescription (Introduction).
- MAT 2 – Service users not in MAT 1 and MAT 4 and using on top (Maintenance).
 - Below OG – in MAT 2 and below 'Orange' guidelines (OG) threshold.
 - Above OG – in MAT 2 and above 'Orange' guidelines (OG) threshold.
- MAT 3 – Service users not in MAT 1 and MAT 4 and not using on top (Maintenance).
 - Below OG – in MAT 3 and below 'Orange' guidelines (OG) threshold.
 - Above OG – in MAT 3 and above 'Orange' guidelines (OG) threshold.
- MAT 4 – Service users on a reduction prescription that can reach zero dose in three months (Detoxification).
- Uncategorised – Sus with no drug test in the last month or no TOP in the last six months.

During the period from August 2019 to Jul 2020 the number of MATs in West Sussex rose from 792 a month to 875 a month, with much of this increase seen in early 2020. Service data also show that there was a notable increase (relative and absolute) in MAT 3 service users, and a decrease in MAT 2, starting in early 2020. This MAT 3 rise specifically denotes those not using drugs on top of their prescription. It is possible that this is due to the lockdown reducing the

supply of heroin in the local market, or other factors, but in any event represents clear health improvements for those service users, with less residents using heroin on top of their prescriptions and more overall seeking treatment.

Figure 8.2, Individuals receiving Medically Assisted Treatments, by MAT category



Source: CGL provider data (2020)

8.3 Lessons learned for the future

Learning from the 2020/21 social restrictions will continue into the future, but this has, under the unusual conditions, provided some real-life experiments in the method of delivery of services, including tele-support and focused community interventions. Some preliminary insights have been drawn from service providers and the wider partnerships, and reviews of this should be collated in the future. An example of this was the expansion of homelessness support during the Spring, 2020, lockdown period.

8.3.1 Housing and temporary accommodation

During the Spring 2020 lockdown, West Sussex residents with housing/homelessness issues were offered temporary accommodation in local hotels and unused hospitality venues (e.g. Butlins in Bognor Regis). After the restrictions ended in the Summer, these occupants were removed back to their previous living arrangements. Initial feedback from community partners involved in local housing support suggests that there were some negative consequences to this action. The belief was that whilst many were well cared for during their accommodation, the knowledge that they would soon be back to their previous circumstances was a further detriment to their mental health. Throughout the pandemic, partners have informed us of deteriorating mental health within this cohort, with higher presentations of overdoses and suicidal ideation.

COVID-19 Response and New Ways of Working, Key Summary:

The nation-wide lockdown of March to July 2020 and the subsequent ongoing policies of reduced interpersonal proximity have led to significant challenges in service provision and wider support mechanisms. Workforce Management and the Staffing/Health and Safety/Governance concerns included an agreed organisational response to ensure consistent Risk Assessments are in place.

The main programme activities, i.e. Medication Assisted Treatment, Alcohol Offer, Harm Reduction activities, have remained in place. Some major providers have agreed to pause face-to-face meetings to assess new referrals, but digital/telecoms channels remained open. This has been kept under regular review. Some work still exists as face-to-face, such as those concerning homelessness support and those interventions for people with higher clinical need. Some services have kept service users engaged, when they might have otherwise completed their treatment and been discharged as a safeguarding measure.

Contacts and check-ups with service users have switched to telephone contacts where possible and preliminary feedback suggests this may be a positive step, as it allows for more flexibility and less missed appointments than when service users are required to go to a central location. Implications for this should be reviewed with professionals and service users to assess the full extent of positive and negative impacts of this change in working.

For the first half of 2020 there was an increase, in relative and absolute terms, in service users receiving Medically Assisted Treatments who were not also using illicit drugs. It has been proposed that this was due in part to the reduction of illicit drugs caused by the national lockdown and this should be monitored long-term to see if this change is sustained.

Those offered temporary accommodation during the Spring 2020 Covid restrictions may have suffered from worsening mental health, due to the disruption this caused to their established living situation.

9. Reflections and Partnership Feedback

The working group for this assessment made the decision to share a copy of the executive summary (Section 1, - which contained all findings from the main report) in late-2020 with the West Sussex community safety managers, public health leads, several members of the Safer West Sussex Partnership executive board and key community partners involved in supporting those with substance misuse issues. This section attempts to summarise their feedback.

Key headings:

- 9.1 Feedback on the needs assessment
- 9.2 Core areas of focus for the future
- 9.3 Known gaps in knowledge or ability to improve services
- 9.4 Suggested priority actions

Those invited to comment included:

- Arun Community Safeguarding Manager
- Chichester Community Safeguarding Manager
- Crawley Community Safeguarding Manager
- Horsham Community Safeguarding Manager
- Mid-Sussex Community Safeguarding Manager
- Worthing and Adur Community Safeguarding Manager

- Turning Tides (West Sussex)
- Stone Pillow (West Sussex)
- Emerging Futures (West Sussex)
- Change, Grow, Live (West Sussex)

- Sussex Police Partnership Manager
- Sussex Police District Commanders
- NHS Commissioners - Adult Safeguarding Lead

- Consultant in Public Health – Living and Working Well
- Public Health Lead - Substance Misuse
- Public Health and Social Research Unit Manager
- Senior Commissioning Manager – Substance Misuse

These stakeholders were asked to feedback their views along the following four strands:

1. Do they accept the approach of the needs assessment in principle; do they recognise the findings as valid and important?
2. What do they think are the core areas which partnerships should be focusing on, as a priority?
3. What can they not address either because they don't have the resources/networks, or because they don't recognise the issues as a priority?
4. Do they have any recommendations overall, which they think the report should include; speaking to systems, partnerships, services, engagement, evaluation/KPIs, etc.?

The feedback from these partners has been combined and absorbed into this final section, in order to ensure that findings and recommendations for future priority actions are workable and realistic, and with the endorsement of these core stakeholders.

9.1 Feedback on the needs assessment

9.1.1 Strengths of the approach

Overall, the partnership feedback was positive, and it was felt that the approach and format of the assessment was both clear and valid. Specific examples included: Easy to understand and factually comprehensive; making sensible conclusions; highlighting the complex interdependencies involved; reflecting local issues and concerns; particularly referencing the link between mental health and substance misuse. - Some noted that the difficulty was not in the presentation or approach, but in gaining commitment to implementing real solutions.

9.1.2 Limitations of the approach

The identified limitations at the draft stage of the assessment mean that we have been able to add context and expand certain areas of the main text, but they are reported here for transparency.

The limitations cited by partners included the clear lack of targeted engagement work in this report and due to this, the report did not identify the barriers to changing the current cultures and ways of working. Whilst this is accepted, it is hoped that recommendations for future engagement work (later in this Section) will be accepted and acted on.

Another limitation cited was the focus on service-level data and population outcomes, whilst speaking less to the community-led (or asset-based) approaches which can empower residents more directly to improve their lives. The authors make note here of the strong level of activities at the community level, and that these same community partnerships will use their exemplary

ways of working in line with these recommendations to create a holistic approach centred around identifying needs and empowering individuals and communities.

A final limitation of note is the shortage of focused work for how issues multiply in people's lives and create problems which become increasingly difficult to overcome. This, now mentioned in Section 2, is acknowledged as a limitation and an outcome of the approach of the report. Issues are discussed in series and not combined, due to the way data and literature are published. It is a requirement in the future therefore for community and service leads to actively expand the conversation around substance misuse issues; to break out of the traditional approach, tackling 'one-issue at a time' and develop ways to discuss issues as a part of individuals real lived experiences.

The age of the data means there is a delay in understanding how service use has changed in the past two years. Commissioning cycles tend to last several years and it would be a benefit to have included NDTMS data from after 2018/19 in many of the figures, which was not available at time of writing.

The lack of engagement with service professionals at time of writing also leaves some questions unanswered, particularly around how to resolve issues of co-occurring issues in NHS mental health presentations. Substance misuse leads are commissioning new solutions to this, and we will make efforts to track the impacts of this work and publish in the future. Commissioners should also continue to seek examples and evidence on what has worked elsewhere which could be valuable in West Sussex.

9.2 Core areas of focus for the future

A range of comments were made as to which findings from the executive summary were the 'Big Issues'.

Mentioned most frequently were the wider issues around proving better care and treatment for those with co-occurring mental health and substance misuse issues.

The continued exclusion of some people with substance misuse difficulties from mental health services was specifically referenced as a priority action for partnerships to resolve. In this some partners mentioned the need to agree a clear and actionable definition of 'co-occurring issues', as different services and areas will have a different approach to treatment and support.

Beyond this were similar issues, as mentioned in Section 9.1, of reforming support for to strengthen a more holistic and personal approach. Where spend and service activity require people to be supported for *issue x*, or *issue y*, it can inhibit support for those whose issues do not fit into predefined categories and combinations. Further, the way that issues can spiral into others means that identifying causal roots to a person's issues may be more difficult but all the more necessary. This in turn creates a need to think more openly about the consequences of such

issues, - for example how street begging increases the visibility of those with housing and substance misuse issues, but also increases tensions in the local community, and may result in negative, rather than sympathetic attitudes.

Younger people were seen as a priority area for several partners, who expressed a need to strengthen partnership working for under 25s drug and alcohol support at a local level.

Further, refocusing on the issues around the criminal justice system was mentioned, particularly in light of the lack of ongoing treatment from prison to community services, and with a clear target to improve outcomes for younger people.

Several community safety managers highlighted the need to use local data to understand challenges and to develop proactive workstreams with local partnerships. The sources used in this report can act as a template for available resources, as well as sharing community partners sharing data where possible.

9.3 Known gaps in knowledge or ability to improve services

The authors note that this needs assessment did not answer all the partners questions regarding wider issues of substance misuse. Responses have been combined and summarised here, with the hope that efforts can be made in the future to adequately address these gaps in knowledge and policy. These issues individually would benefit from short focused reviews or summaries of investigation in the future.

As seen above, many responses commented on the need to answer the question of how to address co-occurring conditions and the integrated complexities which can exist at the individual level. Also referenced in this context were housing and homelessness, particularly seen as an increasing issue due to the ways that Covid restrictions have impacted communities.

Extending this idea, there were numerous references to Psychologically Informed Environments (PIEs). These are services where the day-to-day running has been designed to take the psychological and emotional needs of people with these experiences into account.¹¹⁵ In step with this was an argument that we need to move from a traditional professional-led treatment approach to a community/asset based approach for support services. The question of how to incorporate approaches such as PIE into commissioning could be explored in the future, including how this might look in a tendering exercise.

¹¹⁵ Mental Health Foundation, [Psychologically informed support for homeless people: what it means and why it's crucial](#) (2017)

Some comments highlighted the aforementioned need for more community-level engagement, to fill gaps in knowledge for this needs assessment. Some respondents asked how this could be done and what would the authentic voice of service users look like.

Related to this, some pointed out that there are difficulties that community service providers have in securing meaningful engagement from various health partners at a local level and it is at this level that action is delivered; that there are local opportunities to deliver integrated work that has the potential to make a positive impact in this area. The success factors of which rely on partners willingness to be involved in the conversation. With the endorsement of partners and members of the Safer West Sussex Partnership it would be possible to develop a platform of dialogue and engagement which explores actionable solutions to some of these issues.

With reference to the relative reduction in formal referral pathways, compared to rising self-referrals described in Section 6, we are unsure if we are doing anything differently, for example. through custody process. It was suggested that this should be explored and to see if we can or should make more referrals. This is part of a series of comments made regarding the link between drug use and acquisitive crime. It was suggested that a review of probation service data may hold some answers and how they can contribute in the rehabilitation of ex-offenders who are or at risk of dependency.

Further detail was also requested on young people's involvement and use of drugs and alcohol, as this is an anecdotal priority for some local areas. Further detailed information would be welcome so local leads can understand the full picture and assess local impacts. An example of this was reports of school pupils taking Xanax (a common anxiety medication) and a review into this area could help them us understand whether there is a growing trend in this age group. The Arun Peer Group Conference for example often speaks of concerns of young people's immersion with drug use, supply and links to violence.

Some responses asked how this needs assessment will be clearly linked into the findings of other active needs assessments. Whilst this is a subject-specific piece of work, many of the reports which comprise the West Sussex JSNA use similar sources of evidence, such as the Public Health Outcomes Framework (PHOF). The individual reviews and assessments were previously combined in the West Sussex Joint Strategic Needs Assessment Summary (2019/20)¹¹⁶ which refers to substance misuse directly (pp. 39-43) and includes all the evidence existing before this needs assessment was initiated. Mental health, sexual health, economic inequalities, housing issues and other related issues referenced through this assessment are also included in the JSNA summary.

¹¹⁶ PHSRU, [West Sussex Joint Strategic Needs Assessment Summary: 2019/20](#) (2019)

9.4 Suggested priority actions

There were many suggestions for where policy and services should prioritise action in the future, based on the shared summary findings. These are summarised here to give a platform to the views of these valued partners.

Joined up systems:

- Creating a joined-up system with clear pathways; not cul-de-sacs and communicating the local systems and pathways to all providers and stakeholders, ensuring that cross-referrals do not require repeat assessments. This could alternatively take the form of increasing multi-disciplinary teams, with holistic approaches to support.

Wellness in the community to reduce self-medicating with substances:

- Focus is needed to improve wellbeing in communities so that self-medicating with substances is less desirable/necessary. All Services should recognise trauma informed practice in this context, i.e. reasons for substance use is self-medication for past trauma – and both mental health and substance misuse systems need to be integrated for the benefit of service users.

Tighten relationships within related systems:

- Systems relating to substance misuse and related wellbeing, including sexual health, children's social care and housing, can benefit from closer working relationships at a local level so that professionals are more familiar with ways of working and internal priorities.
- Provide a rolling programme of drug and alcohol training to upskill the wider partnership workforce to increase awareness, knowledge and potentially deliver early / brief interventions; this a current gap.

Increasing engagement and ease of travel through referral pathways:

- Inflexible referral pathways can hinder individuals from accessing services. This merits further exploration and consideration of how services can be designed to increase engagement in the short, medium and long term, whilst facilitating more streamlined self-referral mechanisms.

Developing and improving early intervention:

- Early intervention and prevention should be the primary focus, evidence for this is available and should be utilised around adverse childhood experiences, housing and risk of homelessness and other related systems, and the correlation of these to substance misuse.

- Opportunities to work alongside primary care nurses and GP based paramedics would permit access to evidence-based, effective interventions. Through acting upstream in this manner, concerns may be addressed earlier, preventing, and alleviating pressures on services across all sectors.
- Prevention and end-of-treatment strategies can be improved, to keep service users out of treatment and prevent revolving door cases; particularly for young people in local settings such as schools (e.g. schools in Arun were cited as actively asking for this specialist input and support).
- A specific focus on the consumption and supply of cannabis may help to identify those at risk of developing further relationships with substance misuse.

Maintaining service engagement and reducing unplanned exits:

- Further exploration of support for those who have unplanned exits from services needs to be undertaken on all levels, as reasons for unplanned exits likely differ at the individual level.

Developing practice around coexisting conditions:

- Better co-ordination around mental health and substance misuse support services should be prioritised within all applicable systems.

On Covid-19:

- A review of the impact of Covid 19 on services and on communities will be needed, even going into a post-restriction period.
- Relating to changes made during the Covid-19 restrictions, communities could benefit from further efforts to embed a non-opiate, online interventions model for clients, as well as an additional bespoke programme providing support for clients' families and loved ones, to help address a pressing national need to improve wellbeing. This additional online development could increase capacity for populations which have faced barriers to accessing community-based services, including stigma from friends and relatives.

Criminal justice support and pathways:

- Sustained positive outcomes for prison leavers could be achieved via "bridge building programmes" as part of core delivery. Our partners referenced ownership approaches in the MOJ that have been evaluated that are transferrable into community settings, (Prisons

Addressing Substance Related Offending (P-ARSO)¹¹⁷; a Cognitive Behavioural Therapy which bridged substance misuse interventions with family impact outcomes.

- Multiple issues are impacting on a rise in average ages of incarcerated persons. An expansion of community recovery coaches could act as “proactive services prevent team” keeping people out of mainstream service by adopting a liaison and diversion approach.

Improving service provision:

- The provision of an assertive outreach by local drug and alcohol services, integrated with local partners e.g. police, local authority, housing, charities is needed. This should include increasing availability of treatment options: residential, substitute prescribing for crack / cocaine / cannabis (only opiate) and the promotion of alcohol support service

Education and awareness in the community:

- Renewed focus on the impact and support needed for young people to include a countywide education programme for drugs and alcohol to raise awareness of health and personal risks, provide accurate information and advice on where young people (and parents) can access support.

¹¹⁷ Prisons Addressing Substance Related Offending (P-ASRO): A cognitive behavioural therapy intervention designed to assist prisoners to address illicit drug use and related offending, learn and enhance skills and thinking patterns required to reduce or stop drug misuse and offending. (MOJ, [Glossary of Programmes](#), 2013/14)

Reflections and Partnership Feedback, Key Summary:

The summary to this needs assessment (Section 1) was in late-2020 shared with the West Sussex Community Safety Managers, several members of the Safer West Sussex Partnership executive board and key community partners involved in supporting those with substance misuse issues.

Overall, the partnership feedback was positive, and it was felt that the approach and format of the assessment was both clear and valid. Limitations included the lack of engagement work, meaning that context was missing from the explanation of some of the observed issues and barriers to improvements; this will need to be explored at a later date to continually grow the local evidence base.

Areas to focus on in the future included co-existing mental health issues; supporting people holistically, to take account of individual complexities; an understanding of how the local community interacts with vulnerable groups; strengthening partnerships to support younger people; refocussing on prison leavers; and a need to better employ local data to enable workstreams and partnerships.

Known gaps in knowledge or ability to improve services included how best to support those with coexisting mental health conditions, as well as those in vulnerable groups, particularly homelessness, in light of the community impact of Covid-restrictions. Also highlighted was the need for psychologically informed environments and for a balance between clinical treatments and psycho-social support and asset-based approaches. How these might be incorporated and commissioned was unknown. The question of how to engage and develop the local partnerships to work together in new ways was also raised; as was the opportunity to review probation service data to help inform what could be done to improve outcomes for ex-offenders. Further detail was also requested on young people's involvement and use of drugs, alcohol and possible unregulated use of prescription medications, and how these might link to crime or exploitation.

Many priority actions were suggested by our partners. These included: Joined up systems; Wellness in the community to reduce self-medicating with substances; Tighten relationships within related systems; Provide a rolling programme of drug and alcohol training to upskill the wider partnership workforce; Increasing engagement and ease of travel through referral pathways; Developing and improving early intervention; Opportunities to work alongside primary care nurses and GP based paramedics; Improve prevention and end-of-treatment strategies; A specific focus on the consumption and supply of cannabis; Maintaining service engagement and reducing unplanned exits; Developing practice around coexisting conditions; A regular review of the impact of Covid 19; Sustained positive outcomes for prison leavers; An expansion of community recovery coaches; The provision of an assertive outreach by local drug and alcohol services; and Education and awareness in the community.

10. Recommendations and Gaps in Knowledge

In conclusion of this needs assessment the following recommendations are made, which include recognition of the need for future work to uncover the drivers of our substance misuse-related outcomes and workable actions for the wider partnership.

In terms of who specifically should take these recommendations forward, this report is drafted primarily for service commissioners. It is drafted to inform their planning and commissioning decisions, therefore lead commissioners for substance misuse services, within West Sussex County Council, and mental health commissioners within Sussex Health and Care Partnership are tasked with addressing or overseeing them, but clearly with the support of the wider system.

Co-existing mental health problems

There remains a deep-rooted problem centred on 'dual diagnosis'. People with co-occurring substance misuse and mental health problems, at all levels of severity, face additional barriers in the access, take-up and outcome of treatment and support services. This is a complex issue. There is consensus on the importance of integration and closer multi-disciplinary working to tackle it, as well as an acknowledged difference in reporting/case management systems that services should communicate effectively so that any reporting differences do not create a barrier to communication.

Recommendations

- 1) Whilst there is broad consensus that there should be an integrated response to dual diagnosis, this needs to be explicitly and clearly articulated by senior managers; for example whether the ambition is the use of common assessment tools, common risk management, shared data systems, co-location of staff and agreed referral systems.
- 2) The importance of staff training and organisational cultures, across services and within a local area, has been emphasised by a number of partners. Services should be equipped and ready to respond pre-emptively, and not only to presenting issues.
- 3) A reemphasis on the important principles of a 'No Wrong Door' policy, and 'Making Every Contact Count'; that people with co-existing conditions can access support services (e.g. assessment, information, advice) which addresses their mental health and substance misuse needs in both alcohol/drug and mental health services. This also includes other drivers of morbidity and mortality, such as offering advice on smoking.
- 4) Use of diagnosis/es as exclusion criteria should be avoided and service redesign should be considered as an alternative to exclusion.

Known gaps in knowledge

- 1) Nationally (e.g. NICE NG58) we recognise that people with co-existing conditions are at higher risk of not using or losing contact with services. The number of individuals who have not been able to access or maintain engagement with local services for their needs, due to these reasons is unknown.
- 2) It is likely that persons within this cohort are at greater risk, due to further issues such as homelessness or abuse. Efforts are required to establish how we investigate and respond this. This will also aid our understanding of how co-existing conditions vary between and across groups and how vulnerabilities can be addressed.
- 3) Resultant demand across the system by this cohort is not locally known, for example the increased demand on emergency services, urgent care and criminal justice.

Cumulative Problems and Holistic Approaches

The problem of less severe but cumulative problems, means that people can fall between services at an early stage. There is strong consensus that the needs of individuals should be addressed holistically. Our partners also raised issues in relation to some specific higher risk groups, such as younger adults, ex-offenders, and vulnerable groups such as those with a learning disability. The earlier problems can be identified the better, and a number of suggestions were made in relation to prevention and early identification.

Recommendations

- 1) Substance misuse difficulties and dependencies are less an individual choice and issue to address, but rather part of a much wider social issue that requires a wider social (community) response. At the community and population level, within local areas, further work is needed to challenge social/group norms relating to self-medicating with substances. This is vital to promote a healthier psychological environment, which acts to prevent problems developing and sustain recovery following treatment. This should include ongoing work to tackle denial, and stigma from engaging with support services.
- 2) Explore the development of early warning indicators (at an individual level) to identify escalating issues.
- 3) Strengthen working with the criminal justice system to ensure that pre-release interventions are in place; strengthening of prison to community protocols/procedures.
- 4) To take a holistic approach to individual circumstances, close working is needed at a local level, notably with children's social care, welfare benefit services, and housing providers. This was demonstrated by the positive feedback concerning close working across partnership as part of

COVID homeless response. Links to the social prescribing workforce within primary care could also be explored.

5) Of note housing has been identified as a specific and rising concern (rising due to the predicted impact of Covid-19 restrictions). The funding of specialist or dedicated housing advice staff should be considered.

Known gaps in Knowledge

1) Which local cohorts, beyond broad-level demographics, are driving the increase in alcohol related admissions/episodes? What are the options to tackle the chronic problem of people ending up in hospital from alcohol related problems? How do we understand and address escalating episodes from some residents, with reference to referral pathways into and from hospital settings?

2) What can health service commissioners and adult social care offer each other in terms of supporting older residents drinking at higher risk levels?

3) What are the patterns and volume of service delivery around alcohol brief-interventions and onward referrals, e.g. to treatment services? What are pros and cons in investigating how we might target evidence-based interventions - for example, where there are areas of high/higher hospital admissions?

4) What are the ongoing impacts for parents after planned exits, in terms of supporting them and their families?

Improving Engagement with Service Users and Shared Decision Making

Whilst not higher than national levels, there are still significant numbers of unplanned exits from our services and deaths (from any cause) of those whilst engaged. On the other hand, many are spending six years or more engaged with opiate support services, and whilst this may be appropriate for those individuals, it is prudent to recommend a concerted effort for engagement to evidence improvements here and for elsewhere (i.e. in addressing co-existing conditions and better supporting those with housing problems or other vulnerabilities).

A number of comments were made by our partners which stressed the importance of working with people at different levels:

- at the individual level, in relation to promoting shared decision making between professional and service user;
- the importance of engagement with service users, individually and collectively to inform the development and delivery of services;
- and the need to work using strength-based and asset-driven approach within communities.

Recommendations

- 1) A commitment be made by local leaders to pursue, document and address the findings of different lines of engagement to resolve key areas of concern. This will include efforts to understand the individual contexts and the personal or systemic drivers which lead to the observed outcomes; be they, for example, unplanned exits, increased vulnerabilities, or an unwillingness/inability to initially engage with services.
- 2) In addressing the findings of these lines of engagement local leaders should evidence how such knowledge has informed their activity at the service level, and our policies at the wider systems level.
- 3) Shared decision making should be captured and used by services and more widely in ongoing policy reviews to understand how such practices have impacted on outcomes, particularly in terms of harm reduction and longer-term recovery.

Known gaps in Knowledge

- 1) Addressing the above will require establishing how to strike an appropriate balance or blend of professional-led treatment and psycho-social support.
- 2) This will require a comprehensive understanding of community assets and how they have shifted (particularly in the near future), due to the impact of Covid-19 on vulnerable residents. Reviewing community level assets for individuals on a personal basis and checking these, over time will help us to understand the trends and current position.
- 3) It is important to develop solutions with all our partners; for example, in criminal justice or children's social care, to help fill in the gaps in knowledge for how to better proactively support those later identified in the statistics contained in this report.